Community Benefits Partnership
Annual Report
Fall 2010 through Fall 2011

History of Building a Healthier San Francisco (BHSF) and Health Matters in San Francisco

In response to SB 697, Building a Healthier San Francisco (BHSF), a collaborative of hospitals, foundations, health and human service providers, and community-based organizations, came together in 1995 to develop a broad and effective partnership to address San Francisco's health and human services needs in response to the newly enacted State legislation that required California's private, non-profit hospitals to undertake community needs assessments and develop Community Benefits plans to address those needs. In compliance with SB 697, BHSF has conducted six community needs assessments, which must be completed at least every three years.

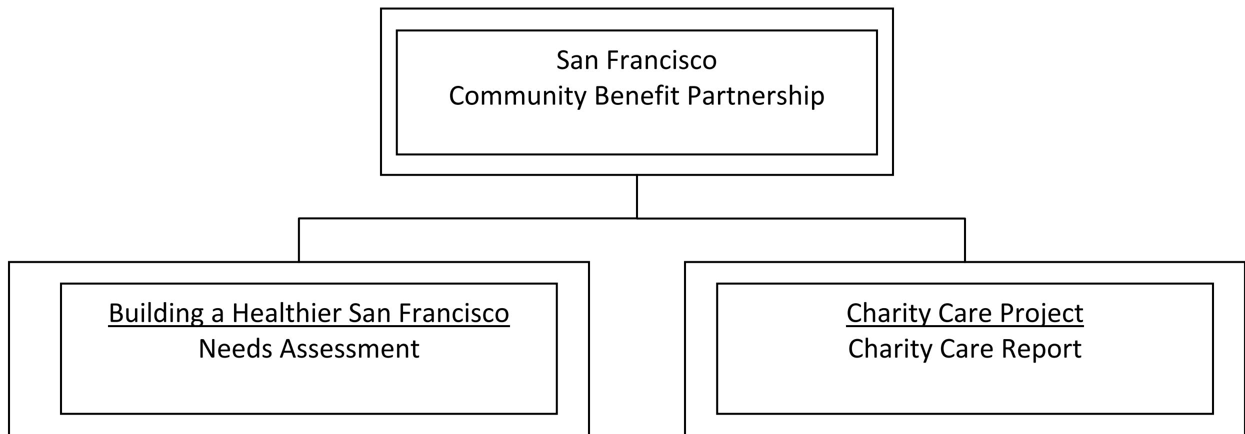
Since 2005, BHSF has worked with Healthy Communities Institute (HCI) to implement a customized web-based information system for San Francisco that functions as an active community needs assessment. The result, the Health Matters in San Francisco (HMSF) website (www.healthmattersinsf.org), was launched on September 26, 2007 to provide San Francisco-specific health data and community resources targeted at community planners, residents, and key decision-makers.

HMSF is the single largest dynamic data warehouse for health information specific to San Francisco and contains quantitative data for more than 100 health and environmental indicators that impact San Francisco's health status. These indicators fall within broad categories such as economy, education, natural environment, public safety, and social environment. The data are the most current publicly available from various sources including the Office of Statewide Health Planning and Development, California Health Interview Survey, San Francisco City and County departments, United States Census, Centers for Disease Control, and other organizations such as the National Cancer Institute. Data for each indicator are provided at the state, county, and/or ZIP Code level, depending on availability. In addition to the raw data, BHSF included an analysis of mortality and hospitalization data, identifying key findings, as part of HMSF.

A final component of the 2007 community needs assessment was the collection of qualitative insights on health care in San Francisco. This process included a series of focus groups that brought together BHSF members, San Francisco Charity Care Project (CCP) members, and community stakeholders to review HMSF's quantitative data and to identify priority areas of need. Community input was collected through focus groups of stakeholders representing a wide range of health and human services agencies, neighborhoods, and populations and coordinated by BHSF, to further identify citywide, neighborhood, and population-specific needs.

The Formation of the San Francisco Community Benefit Partnership

As a result of the 2007 BHSF needs assessment process and CCP, the San Francisco Community Benefit Partnership (CBP) was formed. The CBP seeks to harness the collective energy and resources of San Francisco's private non-profit hospitals, City departments (Public Health and Human Services), community clinics, health plans, and non-profit providers and advocacy groups to improve the health status of San Francisco residents. Graphically, the relationship is:



The CBP came together in spring 2008 to work on four priority areas identified as part of the 2007 BHSF needs assessment process, which could be affected through the collective efforts of the members of BHSF and the CCP. The four priority areas are:

- Improve Access to Care
- Prevent Chronic Disease and Increase Wellness
- Reduce the Incidence of Communicable Disease
- Engage in Violence Prevention

The new structure of the group was designed to maximize both change and efficiency, with CBP intended for high-level discussion and decisions with BHSF and CCP as working subcommittees. BHSF is tasked with producing the community needs assessment every three years, while CCP is responsible for producing the annual charity care report.

Community Needs Assessment Process

As part of the 2010 community needs assessment, the CBP focused on the development of the Community Vital Signs—a dynamic portal to the community's priority health issues, and associated community resources. HMSF is keeping San Francisco vital through its measurement tool for San Francisco's health goals and supporting the infrastructure for community collaborations working to address these goals.

The CBP identified ten priority health goals for San Francisco by enhancing and further defining the four priority areas developed during the 2007 Community Needs Assessment. At a community stakeholder meeting on November 13, 2009, the CBP hosted over 75 participants representing a cross-section of expertise in health and human services. These community stakeholders confirmed the relevance of the ten health goals and planted the seeds for ten affinity groups comprised of subject matter experts for each of the ten health goals. The health goals identified by CBP were adopted by the San Francisco Health Commission on February 2, 2010. The ten goals are:

- Increase Access to Quality Medical Care
- Increase Physical Activity and Healthy Eating to Reduce Chronic Disease
- Stop the Spread of Infectious Diseases
- Improve Behavioral Health
- Prevent and Detect Cancer
- Raise Healthy Kids
- Have a Safe and Healthy Place to Live
- Improve Health and Health Care Access for Persons with Disabilities
- Promote Healthy Aging
- Eliminate Health Disparities

During 2010, CBP embarked on an ambitious year of activity and worked with over 600 stakeholders and content experts from all parts of San Francisco's health community to establish a set of 34 health indicators to guide county-wide planning. The 34 indicators were chosen from a list of more than 350 potential indicators suggested by stakeholders based on the availability and quality of data, existence of benchmarks against which to measure progress, and ongoing availability of data to track progress over time. The product, Community Vital Signs was launched at the 2010 Needs Assessment Breakfast on September 23, 2010 at the Fairmont Hotel. Community Vital Signs is the newest, most effective platform to provide current baseline for each of the indicators and the associated benchmarks, providing a clear and dynamic path forward in promoting the ten priority health goals of San Francisco. It provides a centralized web-based tool for: 1) Assessing the health and health care needs of the city; 2) Guiding health improvement through collaboration; and 3) Evaluating the impacts of health interventions. Progress on these goals as measured by improvements in the 34 indicators is tracked through regular data updates on the Community Vital Signs page on the Health Matters in San Francisco website.

A Landmark Year of Achievements

Following the successful launch of the Community Vital Signs project in September 2010, CBP faced the challenge of how to take the next step: moving the needle on each indicator with a goal to improve the health of San Franciscans.

Members of BHSF agreed to use the Community Vital Signs indicators to guide their community benefits work while recognizing the need to impact the larger community. How would the BHSF Coalition make an impact that stretched beyond their hospital doors? After vigorous internal discussions, the coalition decided that the first step would be to identify the work currently being done across the county that affected these 34 indicators.

Before proposing any new projects, the group developed a schedule for the spring of 2011 featuring monthly meetings of CBP to investigate the current status of each indicator. Members of the coalition worked to recruit knowledgeable, engaged stakeholders and content experts to each meeting. This meeting series was dubbed "Moving the Needle," and it attracted experts from across the broadly defined health community. At each meeting stakeholders discussed the work going on around two of the ten health goals, each goal containing between three to six indicators.

From February 2011 through June 2011, the coalition covered each health goal and indicator. At those five meetings, a total of 94 unduplicated individuals participated providing insight into the current efforts underway to improve the status of, the gaps that exist in securing progress toward, and potential next steps for each indicator. An interesting and not fully expected outcome of these meetings was the relationship building among professionals of separate disciplines who share a common, though unanticipated interest in a particular indicator. For example, colon cancer experts from UCSF traded ideas with administrators from Anthem Blue Cross on payer/provider strategies to prevent and detect colon cancer, and a deputy police chief and an expert from DPH's environmental health team discussed interagency strategies to reduce San Francisco's rate of pedestrian injuries. At every meeting passionate advocates working on the same issues from different points of view would meet each other and exchange ideas for collaboration. After each meeting, the coalition would discuss who attended, with an eye toward stakeholders who might be interested in assisting the project in a more formal manner: as a "Champion."

Champions for the Community Vital Signs

The BHSF coalition needed Champions, individuals working with hospitals, community-based organizations, and City departments who focus on these issues in their daily work, to help organize the approach to move the needle around each indicator. With no full-time staff, the group asked stakeholders to document the current efforts being undertaken on each indicator and compile ideas to potentially improve the status of each one. Champions were asked to complete their indicator reports by answering two basic questions:

1. Assess the current state of activity around your indicator. (Please include a high-level description of any programs, organizations, or community efforts aimed at "moving the needle" of your assigned indicator.)
2. Outline a simple plan or set of ideas to "move the needle" of your assigned indicator. (Please feel free to use bullets or narrative text. Any data, charts, or other supportive documents should be included separately.)

On September 9, 2011, twenty-four Champions met to share their findings, give feedback on the process, and discuss ideas to improve health outcomes in San Francisco. This workshop was a prime example of the rewarding collaboration that has become a hallmark of the CBP process. Gaps were identified and many potential solutions were discussed, from the surprisingly simple to the most complex. As a result, more than 100 project ideas were proposed for moving the needle. In addition, Champions identified multiple opportunities to collaborate on potential projects. Attached are four examples of "Champion Reports," which are being posted on the indicator page of Community Vital Signs on the Health Matters website. They include:

- Percent of San Franciscans Aged 18-64 Who Have Insurance or Are Enrolled in a Comprehensive Access Program
- Chlamydia Incidence Rate
- Age-Adjusted Death Rate Due to Suicide
- Hospitalization Rate Due to Hip Fractures Among Women Ages 65 Years and Older
- Hospitalization Rate Due to Hip Fractures Among Men Ages 65 Years and Older

All of the “Champion Reports” are being posted on the Health Matters website.

Moving Forward

Following the September 9th Champions’ meeting, the coalition has been working to evaluate these ideas in order to support the implementation of those it finds most promising and appropriate to make these policy discussions actionable. The coalition is currently pursuing methods to facilitate communication between the necessary agencies and stakeholders, flesh out proposed programs, and help coordinate the development of actionable projects. In addition, realizing that a volunteer-based committee structure can only carry this effort only so far, CBP is actively searching for funds to expand the staffing support necessary to accomplish the overarching goal to “move the needle” on each of these indicators.

In order to evaluate projects to support, the BHSF work group identified eleven criteria to evaluate those indicators that it should focus on in 2012. The criteria include:

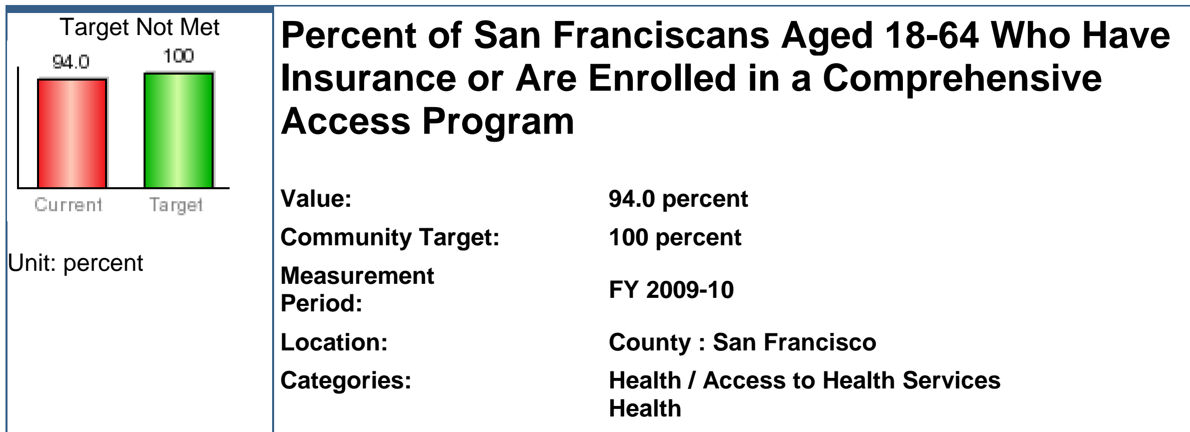
- The indicator represents a health disparity
- There is achievability given the scope of the problem
- Sufficient data exists on the current status of the problem
- There exists a modest capacity to affect change (i.e., the indicator is not so highly resourced such that CBP efforts would provide little added value or not so under resourced that change is unlikely)
- There is a demonstrated problem (i.e., the target is not yet met)
- There is a gap in services or resources
- There is not an existing network with capacity that has already identified this as a priority area
- The Championship Report has identified an actionable project
- The intervention proposed is reasonably doable
- Priority given to interconnected indicators and projects to increase value for resources expended
- BHSF members can make a concrete contribution (expertise, human resources, policy support) to the proposed intervention

As CBP moves forward, the steering committee is mindful of the larger context that exists around community needs assessment and health improvement planning. Below is a chart of external factors affecting the assessment and planning processes and the CBP partner that is impacted.

Mandate or Requirement	Partner Impacted
SB 697 (1994) California Community Benefit Legislation	Non-Profit Hospitals
New IRS Rules under ACA re Community Benefit	Non-Profit Hospitals
Requirements under Public Health Accreditation Board	Department of Public Health
San Francisco Health Care Services Master Plan Ordinance	All
CDC Community Transformation Grant	All

Conscious of the State and new federal requirements related to community benefit, CBP is actively participating in discussions with the Health Department to understand the role it can play in the

Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) that are integral to the Public Health Accreditation Board (PHAB) process DPH is undertaking, the City's Health Care Services Master Plan development, and the CDC Community Transformation Grant implementation in order to ensure that all of the city's health assessment and planning efforts are coordinated, rational, consistent, and working to the same end: improvement of the health of San Francisco in measureable and community-driven ways. Finally, CBP is looking toward 2013 when the next BHSF community needs assessment is due, with a target to see demonstrated improvement on each of the ten health goals.



Percent of San Franciscans Aged 18-64 Who Have Insurance or Are Enrolled in a Comprehensive Access Program

Value:	**94.0 percent**
Community Target:	**100 percent**
Measurement Period:	**FY 2009-10**
Location:	**County : San Francisco**
Categories:	**Health / Access to Health Services** **Health**

What is this Indicator?
This indicator shows the percentage of San Franciscans ages 18-64 who either have health insurance or are enrolled in Healthy San Francisco.

Why this is important: Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all persons in the United States. Clinical preventive care, primary care, emergency services, and long-term and rehabilitative care, with health care delivered by specialists and care received in hospital settings, represent major components of the continuum of care. The public health system is important in each of these areas because it educates people about prevention and addresses the need to eliminate disparities by easing access to preventive services for people less able to use existing health services. It ensures the availability of primary care through direct funding of clinics and providers or by providing public insurance. It coordinates emergency services systems and oversees long-term and rehabilitative care.

The City of San Francisco created a program called Healthy San Francisco that makes health care services accessible and affordable for uninsured residents. The program offers a new way for San Francisco residents who do not have health insurance, to have basic and ongoing medical care.

The Healthy People 2020 national health target is to increase the proportion of people with health insurance to 100%. Though Healthy San Francisco is not health insurance, it represents access to health care for the uninsured population.
Progress in the last year:
In the previous year, the percent of San Franciscans who have insurance or are enrolled in a comprehensive access program was 96.5% while the current year is 94.0%. Please note that the data source changed from last year which is a factor in the change from last year (see Technical Notes).

What is the current status?
(Measuring Period 2009-2010)

Total Population, SF county	809,741
Population 18-64, SF county	581,058
Uninsured population, 18-64	88,005
Uninsured rate, 18-64	11.60%
HSF Enrollment in 2009-2010	53,428
Rate of Uninsured and those not enrolled in a comprehensive health access program	*5.95%*
% of San Franciscans aged 0 - 64 who have insurance or enrolled in a comprehensive health access program	***94.0%***

Sources:

- *ACS 2009: http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-ds_name=ACS_2009_1YR_G00_&-CONTEXT=dt&-mt_name=ACS_2009_1YR_G2000_B27010&-tree_id=309&-redoLog=true&-_caller=geoselect&-geo_id=05000US06075&-geo_id=NBSP&-search_results=01000US&-format=&-_lang=en*
- *HSF Enrollment Figures: Annual Reports FY 09-10 and FY 10-11*

Technical Note & Details

The source of data used to prepare this indicator has been changed from California Health Interview Survey (CHIS) to the American Community Survey (ACS). ACS utilizes a larger sample size increasing the confidence interval. Additionally, the ACS is released annually allowing the measure to be communicated annually.

Updated data from the 2009 American Community Survey (ACS) released in 2010, estimates that 86.4 percent of the 581,058 San Franciscans ages 18-64 had health coverage in 2010.* Enrollment in Healthy San Francisco in August 2010 was approximately 53,400, representing approximately 9.2 percent of San Franciscans ages 18-64. Thus, 94 percent of San Franciscans either have health insurance or are enrolled in San Francisco's comprehensive health care program, Healthy San Francisco.

*Please note that this methodology may lead to an overestimation of the indicator due to 1) the question used in the ACS survey to estimate the total number of adults with insurance may count persons who are enrolled in Healthy San Francisco, leading to possible double counting in this methodology; and 2) potential sample bias - persons likely to be uninsured or not enrolled in a comprehensive health access program are also least likely to be part of the sample size of the ACS, these include groups such as undocumented immigrants, low literacy, mental health/ substance abuse illnesses, etc.

Health Coverage & Access Programs in San Francisco That Support the Indicator "Needle"

State & Federal Public Health Coverage (Insurance) Programs: These include Medi-Cal (Medicaid), Medicare, and Healthy Families Program. These programs combined cover almost 30% of San Francisco's residents. While these programs cover most residents who are medically needy and/or low income, they often exclude immigrants without satisfactory immigration status and childless adults who are not a senior (65 or older) or a person with a disability.

Local Children's Health Coverage (Insurance) Program: Healthy Kids is a local health coverage program for San Francisco children ineligible for State & Federal programs Their incomes may be slightly too high for State/Federal programs or do not meet the immigration status requirements This program combined with State & Federal health coverage programs, employer-based coverage, and private coverage, San Francisco is able to achieve almost universal health care for children and youth under age 19.

Health Care Security Ordinance: The San Francisco Health Care Security Ordinance (HCSO) requires medium and large-sized employers to spend a minimum amount per hour on healthcare for their employees who work in San Francisco. Employers can satisfy this requirement by participating in the City Option, which provides employees Healthy San Francisco or a Medical Reimbursement Account.

Healthy San Francisco: As part of San Francisco's Health Care Security Ordinance, Healthy San Francisco is a health access program that provides access to limited basic health care benefits, specialty services, pharmacy, and hospital care for uninsured San Franciscans ineligible for State & Federal programs and regardless of immigration status. Program income limits are high enough to cover many working adults. Most health centers and clinics that provide health care to the uninsured participate in this program.

SF PATH Program (LIHP & Healthcare Reform): This is a new program started in 2011 and not reflected in 2009-2010 data. Available to uninsured San Franciscans who are low-income and meet immigration status requirements, SF PATH is a federally-funded program that provides affordable medical care to some people living in San Francisco. It is a new way for San Franciscans who meet certain federal requirements to get quality, ongoing medical care. It is similar to Healthy San Francisco in benefits with some exceptions and is an effort to prepare for Health Care Reform. It is not insurance, but a comprehensive health access program (no access outside of San Francisco except for emergency care).

Public Health Program Enrollment Sites: There approximately 56 locations throughout San Francisco where individuals may apply for public health programs. This represents over 250 Application Assistors (persons trained to assist with completing applications). These sites offer services in multiple languages and for multiple programs. Most are located at health care facilities, but are also located at community based organizations. Services also include application assistance to reapply for programs. Many of these sites utilize One-e-App, a web-based enrollment system, to apply for multiple programs at once during one visit.

Community Based Outreach & Retention Efforts: NICOS Chinese Health Coalition, San Francisco Health Plan, the Healthy Kids Program and various other community agencies actively participate in community outreach to educate and inform the uninsured about public health coverage programs. There are similar efforts to educate and inform existing public health program participants to continue their coverage through application assistance and navigation

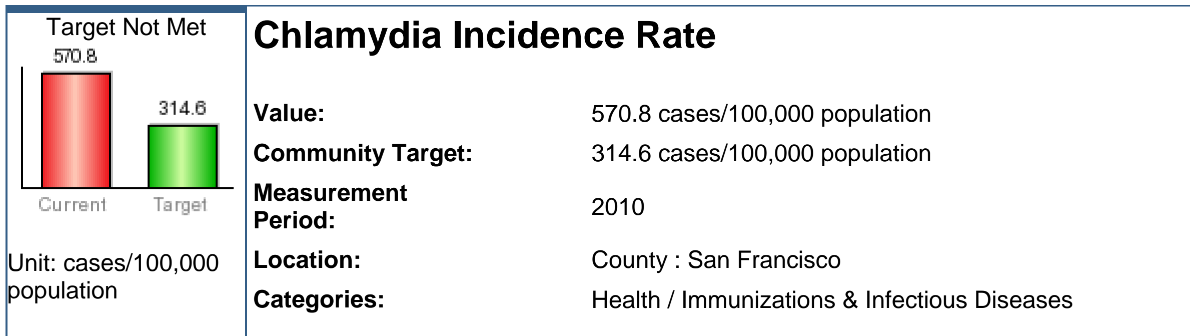
of the health program administrative process. Through the San Francisco Health Plan, a network of community based organizations and public agencies also gather on a bimonthly basis to stay informed on public health program information and outreach opportunities.

What is needed to "move the needle"?

1. Align health program enrollment workflows with medical appointment workflows (at medical home sites)
2. Supporting a no-wrong door approach in SF
3. Invest and support one application for all available public health programs (i.e., One-e-App)
4. Promote interagency coordination between social and health program services when determining eligibility
5. Similar to Homeless Connect, host a city-wide event called Health Coverage Connect (2-3x per year)
6. Utilize peer health promoters to reach the hardest to reach uninsured populations

Who are the Community Partners on this Indicator?

San Francisco Health Plan (www.sfhp.org)
Healthy San Francisco (www.healthysanfrancisco.org)
SF PATH (www.sfpath.org)
San Francisco Department of Public Health (http://www.sfdph.org/dph/default.asp)
Healthy Kids (http://www.sfhp.org/visitors/programs/healthy_kids/)
State Program - Healthy Families Program (www.healthyfamilies.ca.gov)
Medi-Cal Health Connections (http://www.sfhsa.org/102.htm)
NICOS Chinese Health Coalition (http://www.nicoschc.org/)
San Francisco Community Clinic Consortium (http://www.sfccc.org/)
Bringing Up Healthy Kids Coalition



Chlamydia Incidence Rate

Value:	570.8 cases/100,000 population
Community Target:	314.6 cases/100,000 population
Measurement Period:	2010
Location:	County : San Francisco
Categories:	Health / Immunizations & Infectious Diseases

What is this Indicator?
This indicator shows the Chlamydia incidence rate in cases per 100,000 population.

Why this is important: Chlamydia, the most frequently reported bacterial sexually transmitted infection (STI) in the United States, is caused by the bacterium, Chlamydia Trachomatis. Although symptoms of Chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur "silently" before a woman ever recognizes a problem. Chlamydia also can cause discharge from the penis of an infected man. Under-reporting of Chlamydia is substantial because most people with Chlamydia are not aware of their infections and as a result do not seek testing.

Several factors contribute to the high rate of Chlamydia in San Francisco. Chlamydia screening rates are relatively high in San Francisco. As a result a large amount of asymptomatic infections are identified. Furthermore, in addition to urogenital testing, which is conducted by all jurisdictions and exclusively conducted by many, San Francisco also performs rectal and pharyngeal testing for Chlamydia. The identification of Chlamydia infections in extragenital sites also contributes to the higher rates seen in San Francisco.

The Community Target of 314.6 cases per 100,000 population represents the 90th percentile among U.S. Metropolitan Statistical Areas (MSA). That is, only 10 percent of MSAs have lower rates. The 90th percentile target was borrowed from the County Health Rankings project, which chose this measure because it struck a balance between achievability and improvement for most jurisdictions.

Progress in the last year:
In 2008, the Chlamydia incidence rate was 530.4 cases/100,000 population while the 2010 incidence rate is 570.8 cases/100,000 population.

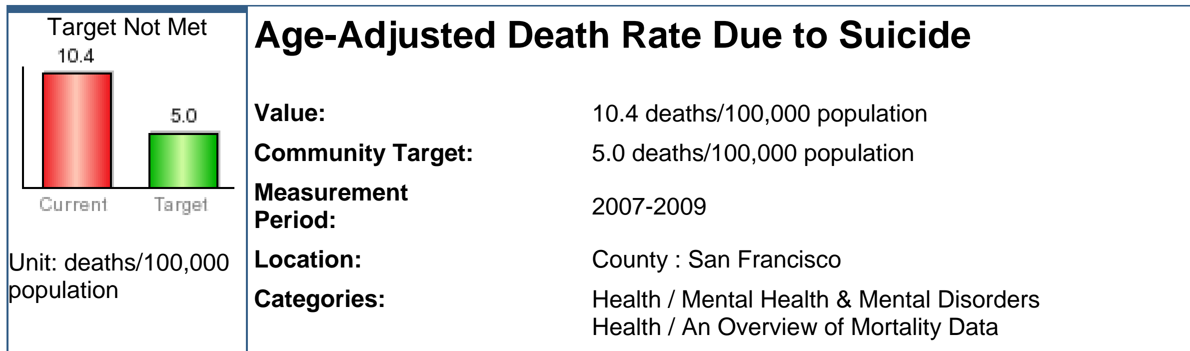
What is the current status?
By law, all positive Chlamydia test results must be reported to the STD Prevention and Control Services Section (SFSTD) of the SFDPH by diagnosing providers and laboratories. The underlying basis for trying to “move the needle” must be having accurate data - both for internal planning and for sharing with community and providers. SFSTD Epidemiologists confirm and count all the cases that are reported and look for patterns in demographics such as age, neighborhood, diagnosing provider that may help guide prevention efforts. These data are then shared publicly via the STD monthly report and the Annual Report, both available on the City Clinic website: www.sfcityclinic.org.
Reducing Chlamydia Incidence is a focus of a specific CDC grant awarded to the STD Section - the Infertility Prevention Project (IPP). As part of this, SFSTD supports Chlamydia screening programs for women under 26 years of age at over 30 clinical sites, including DPH primary care clinics. Also due to IPP, our Chief Epidemiologist meets biannually with colleagues from DHHS Region 9 - both public health and Title X representatives - in order to continue to improve screening efforts.
Because U.S. Preventive Service Task Force (USPSTF) recommendations list Chlamydia screening in women under 26 as a class "A" intervention, SFSTD works with providers and media to increase awareness of the importance of asymptomatic screening. At the same time, SFSTD aims to reduce DPH resources that are used for screening older women, who have lower rates of infection.
Adolescent females have among the highest rates of Chlamydia, and African American adolescents are a particularly high risk group. SFDPH has had a program called YUTHE (Youth United Through Health Education) since 1997 that promotes sexual health and the importance of screening using a peer educator model in the Southeast neighborhoods of San Francisco.
Rates of Chlamydia are also high in the SF jails, and SFDPH has been trying to revise and improve approaches to screening these individuals.

Providers who see gay men, men who have sex with men (MSM), or transgender individuals are encouraged by SFSTD per our screening guidelines to screen routinely for syphilis through a blood test, and gonorrhea and Chlamydia at the pharynx and rectum if the individuals reports receptive oral and anal sex (with or without a condom) every three to six months. SFSTD in partnership with the public health lab have worked to make rectal and pharyngeal testing more widely available to laboratories and providers. HIV uninfected MSM with diagnosed with rectal gonorrhea and Chlamydia infections have been shown to have significantly higher risk of subsequent HIV infection.

What is needed to "move the needle"?
Interventions to reduce the incidence of Chlamydia include:

- Continue to improve the quality of data for monitoring screening, including the number of eligible persons offered screening at primary care. These data are not readily available currently.
- Develop new ways to limit screening of non-recommended populations and increasing screening coverage in recommended populations.
- Increase screening coverage in the county jails, as this is a very high risk population.
- Incorporate screening reminders into new electronic health record (EHR) systems as they are being introduced.
- Incorporate verification of recommended treatments for Chlamydia and gonorrhea into EHRs.
- Explore new funding mechanisms for screening, particularly with the introduction of healthcare reform, so that public dollars for screening can be reserved for those individuals who would not otherwise be covered.

Who are the Community Partners on this Indicator?
African-American Health Disparities Project
Hospital Council of San Francisco
San Francisco Department of Public Health, STD Prevention and Control Services
Youth United Through Health Education (YUTHE)



Age-Adjusted Death Rate Due to Suicide

Value:	10.4 deaths/100,000 population
Community Target:	5.0 deaths/100,000 population
Measurement Period:	2007-2009
Location:	County : San Francisco
Categories:	Health / Mental Health & Mental Disorders Health / An Overview of Mortality Data

What is this Indicator?
This indicator shows the age-adjusted death rate per 100,000 people due to suicide.

Why this is important: Suicide is a major, preventable public health problem. In 2007, suicide was the 11th leading cause of death in the United States. Based on 2007 age-adjusted death rates, men were nearly four times more likely to die of suicide than females, and white individuals were over two times more likely to die of suicide than black or Hispanic individuals. Older Americans are disproportionately likely to die by suicide. An estimated eight to 25 attempted suicides occur per every suicide death.

Progress in the last year:
In the previous year, the age-adjusted death rate due to suicide was 10.7 deaths/100,000 population while the current year is 10.4 deaths/100,000 population.

What is the current status?
SF Suicide Prevention:

- The suicide prevention hotline, which is the oldest suicide prevention hotline in the United States, talks to 200 people a day.
- The average age of callers is going up, even though community age is not going up. Realized that younger people are not using phone, so SF Suicide Prevention put in chat and e-mail service.
- SF Suicide Prevention offers “intervention” but is called “prevention.” They try to push them back away from suicide, but don’t have the resources to really do prevention.
- The organization has analyzed ages, ethnicities, and other data related to local suicides and realized that the opportunity for prevention is likely in health care. Many people who commit suicide have seen a physician within one month prior to the suicide. People who have made an attempt at suicide and were treated are likely to do so again soon after.
- Trying to establish dialogue with medical professionals. The organization has a doctor as an intern right now.
- SF Suicide Prevention operates a number of other services including an alcohol-and-drug hotline, an AIDS nightline (after 5 p.m. when others close), and a youth training service for middle and high schools to teach peer support.
- Suicide hotline becomes 211 from 5 p.m. – 9 a.m.
- SF Suicide Prevention has created a set of suicide prevention strategies, and shared them in a handout to the group.

HOSPITAL COUNCIL SUICIDE STRATEGY: OUTLINE OF APPROACHES

1. **Work from Particular Characteristics of Community Suicides**
    - Methods
    - Age Groups
    - Ethnicities
    - Economic Hazards
    - Sexual Minorities
    - Addictions
    - Trauma Exposure/Critical Life Events
    - Mental Illnesses
    - Primary Care Awareness

2. **Removal of Lethal Methods**
    - Barriers/Nets on popular jump sites
    - Medical/Social Service questions re: guns in home
    - Safe Disposal of Unused Prescription Medications
    - Blister Packaging of NSAIDS

3. **Awareness of Age Groups at Risk**
    - Youth at high risk for attempts, especially young women of color
      (Training in schools for mutual assessment/referral to care)
    - Young Adults, 20-39: Isolated, insulated, high numbers, high impulsiveness
      (Information/training in colleges/workplaces/entertainment)
    - Mid-Age, 40-59 – Possible economic cause for downward shift in risk
      (Primary Care/Libraries/Workplace information, training)
    - Older Adults 60+ : High risk due to isolation, medical challenges
      (Primary Care/Caregiver/Agency information, training)

4. **Ethnicities**
    - Caucasian/European American rates are highest
    - Asian American rates next highest, but much lower
    - Latino/African American rates lowest
    - "Masked" suicides occur in communities with low "official" rates

5. **Economic Hazards**
    - Job Loss (Information/training at EDD, Outplacement Services)
    - Income Loss (Information/training at Credit Counseling Services)
    - Loss of Housing (More Low-income housing in community.)

6. **Sexual Minorities**
    - Bullying re: Orientation/Gender (School/Workplace Awareness)
    - Family Rejection re: Orientation/Gender (Mentorship Programs)
    - Self-rejection (Help-Lines, Websites, Chat Services, Chat Rooms)

7. **Addictions and Mental Illnesses**
    - (Accessible treatment at early stages with insurance coverage)
    - (Effective treatment of co-occurring disorders)
    - (Effective involvement of family/friendship systems)
    - (Workplace/School education/training)
    - (Peer Counseling Services)

8. **Trauma Exposure/Critical Life Events**
    - Military Service/Veteran Status (Early PTSD services)
    - Divorce/Death of Spouse/Child (Grief, Support Groups)
    - Life-threatening Illness (Counseling, Support Groups)
    - Natural Disaster (Community Mental Health Services)

9. **Primary Care Awareness**
    - Most attempters have made a primary care visit within previous month
      (Primary care practitioner training in assessment/referral)
      (Discussions of removing methods of harm.)
    - Chronic Pain challenges bring suicide risk
    - Primary care may be setting for indirect signs and statements (Ask!)
    - Cutting Behavior may or may not be suicidal

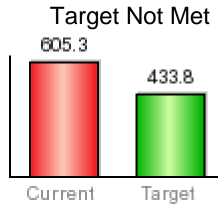
10. **High Risk Behaviors may be "Masked" Suicides**
    - Peer Violence
    - Substance Abuse
    - Unsafe Sex
    - Risky Driving
    - Other risk-taking acts

What is needed to “move the needle”?

1. Initial Workgroup Planning meeting with Key Players to develop:
   a. Agreement on "Working from the Particulars" focus.
   b. Initiate call to Medical Examiner for Data
   c. Think about who else needs to be invited to Suicide Reduction Workgroup.
2. Second meeting:
   a. Examine Preliminary 2010 Suicide Data
   b. Narrow alternative solutions and focus
   c. Build network for collaborations (sub-committees?)
3. Third meeting:
   a. Finalize planning
4. Launch 1 year Multi-tier Services Project and Training Conference as needed.

Who are the Community Partners on this Indicator?

Kaiser, San Francisco
San Francisco Department of Public Health, Community Behavioral Health Services
San Francisco Suicide Prevention



Unit: hospitalizations/100,000 population

Hospitalization Rate Due to Hip Fractures Among Women Ages 65 Years and Older

Value:	605.3 hospitalizations/100,000 population
Community Target:	433.8 hospitalizations/100,000 population
Measurement Period:	2007-2009
Location:	County : San Francisco
Categories:	Health / Older Adults & Aging Health / Prevention & Safety

What is this Indicator?
This indicator shows the average annual age-adjusted hospitalization rate due to hip fracture per 100,000 females aged 65 and older.

Why this is important: The most serious fall-related injury is hip fracture. Approximately 212,000 hip fractures occur each year in the United States among adults aged 65 years and older; 75 to 80 percent of all hip fractures are sustained by females. The impact of these injuries on the quality of life is enormous. Half of all elderly adults hospitalized for hip fracture cannot return home or live independently after the fracture. Interventions that reduce the risk of seniors falling will yield significant public health benefits.

The Community Target of 433.8 cases per 100,000 population represents the 90th percentile of all California counties. That is, only 10 percent of California counties have lower rates. The 90th percentile target was borrowed from the County Health Rankings project, which chose this measure because it struck a balance between achievability and improvement for most jurisdictions. Rates based on less than 5 hospitalizations are not statistically reliable and were not reported.

Progress in the last year:
In the previous year, hospitalization rate due to hip fractures among women ages 65 years and older was 581.5 hospitalizations per 100,000 population while the current year is 605.3 hospitalizations per 100,000 population.

What is the current status?
The Department of Aging and Adult Services (DAAS) offers, coordinates and collaborates with various community-based organizations (CBO) that directly and indirectly affect these indicators. Preliminary review of programs and services that likely affect the "moving the needle" of reducing the hospitalization rate due to hip fractures among males and females 65+ are:

A. DAAS funded Health Promotion programs including:

1. Always Active Program: The Always Active program offers older San Franciscans comprehensive arrays of wellness programs that include: group exercise classes, fall prevention workshops, health education workshops, and one-on-one consultation with nationally certified personal trainers, following approval from respective physicians. Classes and programs include: (a) Basic and Advanced level exercise classes to improve strength, balance and flexibility. (b) Health Education Workshops to focus on chronic diseases and self-management programs. (c) Fall Prevention Exercise Classes that target clients with history of falls/fall risk or "previous fallers." (d) Wellness Trainer and Certification workshops intended to develop knowledge and skills for sustainable exercise programming.

2. Healthier Living: Managing Ongoing Health Conditions (on-line healthier-Living-SF.eventbrite.com). A 6-week Workshop that promotes pain and stress management, good nutrition, exercise, management of chronic diseases, and how to communicate and set goals with healthcare provider.

B. Community Educational Series and training programs, including on site education and training of consumers and service providers at the senior centers, including the Bethany Senior Center.

C. Case/Care Management Training Academy and Resource Fairs, through the Felton Institute. The Felton Institute provides training and coaching using the strength-based Care Management Model. Participants are contracted

community based care managers, DAAS employees, and other collaborating agencies. The mission of the education and training program/training academy has been to increase effectiveness in all levels of care providers, to create the conditions by which integration across the system of care managers who are providing services focused on coordinating assistance, care and support needed by older adults and younger adults with disabilities.

D. Healthy Aging Summit - To promote advances in healthy aging, to increase awareness on new and innovative programs that are likely to impact identified indicators.

E. Community Partnerships - Explores needs/expressed preferences of various San Franciscans relating to healthy aging and communities becoming accessible to older San Franciscans.

What is needed to "move the needle"?

1. To promote community awareness on existing Fall Prevention Programs currently offered and funded through DAAS, community partners, and agencies; including fall prevention programs offered by Rebuilding Together SF and Meals on Wheels.

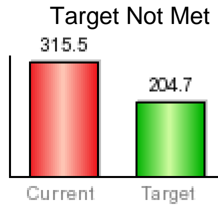
2. To adapt evidenced based Fall Prevention Program in various centers/agencies/services that serve client who are moderate to high risk for falls.

3. To plan, implement and evaluate Fall Prevention Awareness Week - Focusing on Senior Centers, Senior Housing, exercise programs and Meals Sites.

4. To integrate evidence based practices, Fall Prevention, Fall Risk Assessment, in the development of community service plans/treatment plans/interventions for both active and less active San Franciscans through resource fairs and education and training of community based organizations.

Who are the Community Partners on this Indicator?

Community-based organizations including community-based case managers, home delivered meals, and senior centers
Hospitals and clinics
Homecare services
Transitional care services
Department of Aging and Adult Services



Unit: hospitalizations/100,000 population

Hospitalization Rate due to Hip Fractures Among Men Ages 65 Years and Older

Value:	315.5 hospitalizations/100,000 population
Community Target:	204.7 hospitalizations/100,000 population
Measurement Period:	2007-2009
Location:	County : San Francisco
Categories:	Health / Older Adults & Aging Health / Prevention & Safety

What is this Indicator?
This indicator shows the average annual age-adjusted hospitalization rate due to hip fracture per 100,000 males aged 65 and older.

Why this is important: The most serious fall-related injury is hip fracture. Approximately 212,000 hip fractures occur each year in the United States among adults aged 65 years and older; 75 to 80 percent of all hip fractures are sustained by females. The impact of these injuries on the quality of life is enormous. Half of all elderly adults hospitalized for hip fracture cannot return home or live independently after the fracture. Interventions that reduce the risk of seniors falling will yield significant public health benefits.

The Community Target of 204.7 cases per 100,000 population represents the 90th percentile of all California counties. That is, only 10 percent of California counties have lower rates. The 90th percentile target was borrowed from the County Health Rankings project, which chose this measure because it struck a balance between achievability and improvement for most jurisdictions. Rates based on less than 5 hospitalizations are not statistically reliable and were not reported.

Progress in the last year:
In the previous year, hospitalization rate due to hip fractures among men ages 65 years and older was 319.2 hospitalizations per 100,000 population while the current year is 315.5 hospitalizations per 100,000 population.

What is the current status?
The Department of Aging and Adult Services (DAAS) offers, coordinates and collaborates with various community based organizations (CBO) that directly and indirectly affect these indicators. Preliminary review of programs and services that likely affect the "moving the needle" of reducing the hospitalization rate due to hip fractures among males and females 65+ are:

A. DAAS funded Health Promotion programs including:

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Transitional care services
Department of Aging and Adult Services