Update to the Jurisdictional HIV Prevention Plans for the City and County of San Francisco, San Mateo County, and Marin County

A report to the Centers for Disease Control and Prevention

September 2014

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ACKNOWLEDGEMENTS

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Update to the Jurisdictional HIV Prevention Plans for the City and County of San Francisco, San Mateo County, and Marin County

INTRODUCTION

Background

The last several years have seen remarkable changes in the landscape of HIV prevention. The widespread adoption of treatment as prevention, the advent of pre-exposure prophylaxis (PrEP), and the development of new technologies for early detection of HIV are just a few of the many examples of advances that have the potential to fundamentally alter the trajectory of new HIV infections. In 2014, the vast array of effective HIV prevention, care, and treatment tools available to us have given rise to a hope that we could see an end to new HIV infections and a possible cure within a generation. The San Francisco Jurisdiction (which includes San Francisco, San Mateo, and Marin counties) continues to be a leader in this new HIV prevention paradigm, while holding true to the value that HIV prevention can only succeed if we engage affected communities in the planning and delivery of programs.

This update to "The Jurisdictional HIV Prevention Plans for the San Francisco MSA, 2012-2016" highlights successes to date, and begins to outline the many new challenges that await us in the coming years. We believe that "getting to zero" – zero new infections, zero AIDS-related deaths, and zero stigma – is within reach. A comprehensive and inclusive planning process to craft our strategy for achieving this ambitious goal will begin in 2015.

The **San Francisco Jurisdiction** includes San Francisco, San Mateo, and Marin counties, and this Plan is intended to offer a unified vision for HIV prevention across the three counties. It is important to note, however, that the vast majority of new HIV infections in the Jurisdiction are among people living in San Francisco, and thus the data and priorities outlined in this Plan are largely driven by San Francisco. Therefore, caution should be exercised when interpreting data and priorities, and approaches may need to be tailored to each county's context, particularly in light of the fact that San Mateo and Marin counties have far fewer HIV prevention resources. Where possible, data is integrated for the three counties.

The Current State of HIV

The advances in our knowledge about effective HIV prevention strategies and new HIV prevention technologies, and the Jurisdiction's rapid implementation of this new science, have made a broad vision for healthy people and communities possible. Already we are seeing the results of our efforts. New HIV infections appear to have decreased (Exhibit 1). The number of people living with HIV (PLWH) is steadily increasing due to decreases in mortality (Exhibit 2).

We are cautiously optimistic that the downward trend in new HIV infections is in fact a real one. While no one can say for sure what factors have led to the decreases in HIV incidence, it is plausible that the SF Jurisdiction's community engagement approach, combined with rapid implementation of new scientific advances, have led to the lowest rate of undiagnosed HIV infection in the country (6.4% in SF vs. 18% nationally [CDC 2013]) and viral load suppression rates that far surpass the national average (68% in SF vs. 25% nationally [CDC 2013]). In other words, "'treatment as prevention' may be occurring in San Francisco" (Raymond et al 2013).

Some of the factors that have arguably contributed to these successes include:

- The SF Jurisdiction's realignment of HIV prevention funding in 2011/2012 to implement high-impact prevention
- An increase in HIV testing in SF
- Increased emphasis on early linkage to care and partner services (e.g., the Linkage Integration Navigation Comprehensive Services, or LINCS, program)
- Increased availability of pooled RNA testing to detect acute HIV infection beginning in 2011. Eighty-two acute diagnoses were made between November 2011 and October 2013 (Dr. Stephanie Cohen, personal communication, August 2014).
- SF's early adoption of a "universal offer of treatment" policy in 2010
- Ready accessibility of post-exposure prophylaxis (PEP) through SF City Clinic (the City's STI[1] clinic) and early adoption of pre-exposure prophylaxis (PrEP) in SF
- The SF Jurisdiction's ongoing commitment to community engagement, in citywide planning as well as at the level of services
- The HIV Prevention Planning Council's (HPPC's) consistent recommendations that funding be allocated based on the local epidemiology

Last, but most definitely not least, people living with and at risk for HIV (PLWARH) deserve recognition for bringing their voices to the table, embracing prevention, and making the decisions and choices – both individually and as a community – that have led us to a place where "getting to zero" is a real possibility.

[1] In this Plan, the term STI is used. Experts in sexual health use both terms, STD and STI.

Exhibit 1: HIV Incidence Trends

City and County of San Francisco

Source: SFDPH 2013

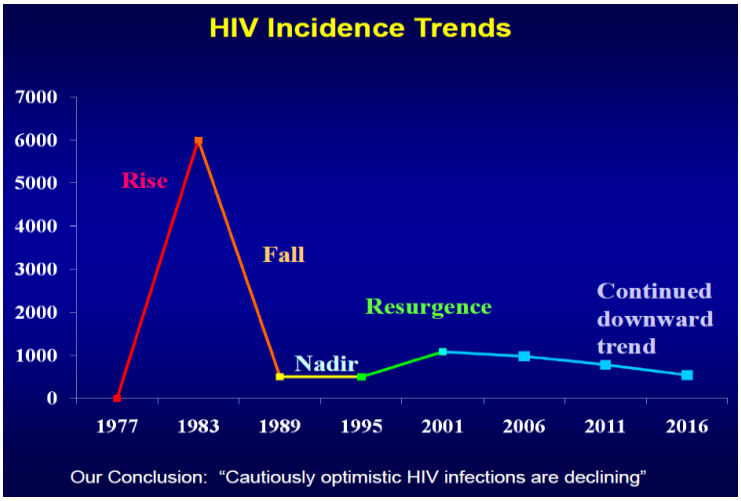
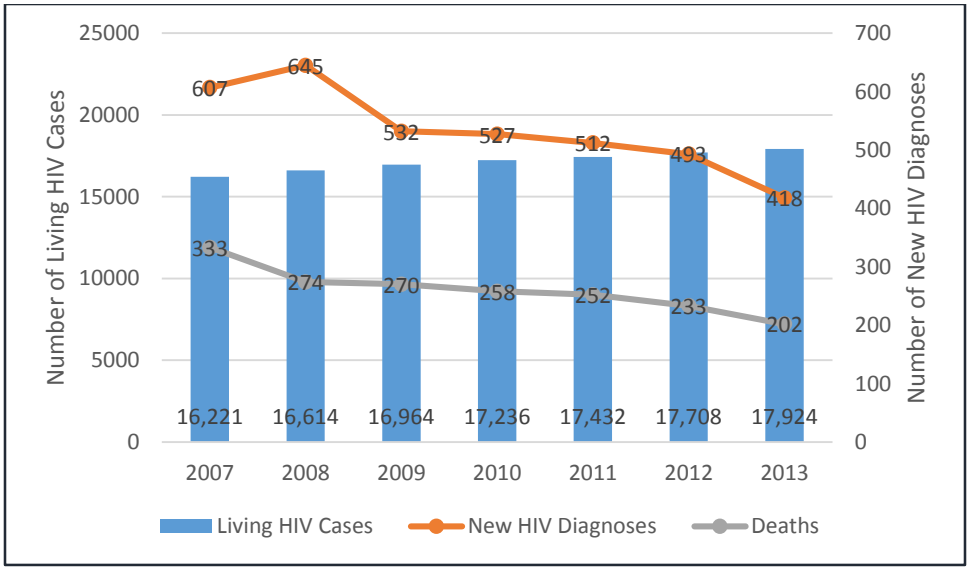


Exhibit 2: New HIV Diagnoses, Deaths, and Prevalence

SF Jurisdiction

Source: SFDPH 2013



Despite these promising trends, HIV-related disparities remain and we will not achieve our goals unless we prioritize addressing these disparities and their root causes. Exhibit 3 summarizes San Francisco data on populations experiencing disparities. In San Mateo and Marin counties, numbers of cases are relatively fewer and thus it's challenging to identify statistically significant disparities. However, San Mateo sees a need to focus efforts on Asian & Pacific Islander men who have sex with men (MSM) and North County. Marin sees a need for increased focus on Latino MSM.

In addition, a possible unintended consequence of the success of "treatment as prevention" is a recent rise in sexually transmitted infection (STI) rates, especially among MSM. This challenge is discussed in more detail later.

Exhibit 3: HIV-Related Disparities, 2014

City and County of San Francisco

Source: SFDPH 2013

Indicator	Populations with Disparities*
HIV prevalence	▪ MSM ▪ Transfemales ▪ African American MSM ▪ African American transfemales ▪ 50 years and older
Estimated Rate of new infections*	▪ MSM ▪ Latinos ▪ Age group 13-29 yo
Less likely to achieve antiretroviral therapy (ART) initiation**	▪ Females, ▪ African American ▪ API ▪ Native American ▪ Multi-racial ▪ Heterosexual ▪ Homeless ▪ Public or No insurance at diagnosis
Less likely to achieve viral suppression***	▪ Female ▪ Transgender ▪ African Americans ▪ Current age under 40 yo ▪ PWID, MSM and non-MSM

For the purposes of this table, "disparity" is defined as when a population is disproportionately affected by an issue, either compared to a reference group (e.g., African Americans compared to whites) or compared to their relative population size.
*Compared to the overall rate of new HIV infections per 100,000 (62 per 100,000) these groups have notably higher new infection rates.
**Compared to overall estimate of 91% receiving ART groups with notably lower ART initiation.
***Compared to overall estimate 62% among living cases with viral load in 2012.

Looking to the Future

Now is the time to celebrate and build on our successes, and to work towards health equity for all populations. "Getting to zero" – zero new infections, zero AIDS-related deaths, and zero stigma – is within our reach for the first time in the history of the epidemic. The Jurisdiction is faring better on most indicators compared with the state of California and the U.S., and has already achieved some of the National HIV/AIDS Strategy (NHAS) targets (SFDPH 2013).

The SF MSA 2012 Jurisdictional HIV Prevention Plans outlined ambitious goals for 2017 for each county. In 2014, we commit to aligning our goals across counties, and in accordance with NHAS. Exhibit 4 shows our progress to date. The takeaway message is that the SF Jurisdiction is making marked progress

towards achieving a reduction in new infections and improved health outcomes for PLWH, but needs to reinvigorate its efforts in the coming years to reduce disparities.

A few data points and trends are important to monitor in SF because they may indicate a need for adjustments to programmatic efforts:

- Nationally there is an increase in new diagnoses among MSM aged 13-24 (CDC 2014). While new diagnoses remain low among 13-18 year olds in SF (SFDPH 2012), SFDPH is closely monitoring data for 18-24 and 24-29 year olds to see if new diagnoses are stable or increasing.
- SF National HIV Behavioral Surveillance (NHBS) data from 2012 suggests that 50% of IDUs in who have HIV do not know they are infected.
- Trends in substance use among MSM are changing, with meth use on the decline and poppers and cocaine use on the rise.
- Late diagnosis is decreasing, and linkage to care and viral suppression rates are increasing, suggesting a need to identify and expand the best practices in these areas.

Exhibit 4: HIV Prevention Goals

SF Jurisdiction

Goals	Indicators	Data	Overall Trend
Reduce new HIV infections	*New diagnoses*	2011: 510 2012: 495 2013: 418 *SF, San Mateo, and Marin. Source: County HIV surveillance data.*	
	Estimated % of MSM in SF who are unaware of their HIV-positive status	2005: 23% 2008: 17% 2011: 6% *SF only. Source: NHBS.*	
Increase access to care and improve health outcomes for PLWH	*Linkage to care*	2011: 84% 2012: 86% 2013: 89% *SF and Marin only. SF data is linkage to care within 3 months. Marin data is linkage to care within 6 months. Source: County HIV surveillance data.*	
	Late diagnosis	2010: 26% 2011: 24% 2012: 21% *SF only. Data represents the proportion of new HIV diagnoses that developed AIDS within 3 months of diagnosis. Source: County HIV surveillance data.*	
	Viral suppression	2010: 56% 2011: 58% 2012: 68% *SF only. Data represents the proportion virally suppressed within 12 months of diagnosis. Source: County HIV surveillance data.*	

Reduce HIV-related disparities and health inequities	*See Exhibit 3*	**No Change**

Measuring Our Progress

In keeping with the fourth NHAS goal related to improving coordination across federal agencies and streamlining data collection, the SF Jurisdiction will take the lead on establishing a core set of indicators that will be used to mark our progress toward "Getting to Zero." These indicators will be established by harmonizing data elements and definitions across the multiple requirements. (For example, instead of measuring linkage to care in several different ways, we will strive to measure it one way.) We will coordinate with local experts and federal funders to ensure that stakeholders' core needs are met and that we are able to measure population-level outcomes as well as performance targets. Given limited public health resources, it is no longer feasible to continue to measure and report on the dozens if not hundreds of indicators that are requested from or required of jurisdictions by various funders and stakeholders – a core set of locally meaningful indicators is needed. Harmonization will take into account the following:

- Institute of Medicine (IOM) indicators (http://www.iom.edu/Reports/2012/Monitoring-HIV-Care-in-the-United-States.aspx)
- Common indicators for Department of Health and Human Services (DHHS)-funded programs and services (http://aids.gov/pdf/hhs-common-hiv-indicators.pdf)
- HIV headline indicators for the SFDPH Population Health Division
- HPPC Measurements of Success
- HIV Prevention Section 2010 Request for Proposals (RFP) goals and outcomes and agency performance targets
- PS12-1201 funding opportunity announcement (FOA) objectives
- PS12-1201 Comprehensive Plan goals and targets
- Enhanced Comprehensive HIV Prevention Planning (ECHPP) goals and objectives
- Health Services and Resources Administration (HRSA) HIV/AIDS Bureau (HAB) and other Ryan White CARE Act indicators
- SFDPH Primary Care Continuous Quality Improvement measures
- Spectrum of engagement in care indicators

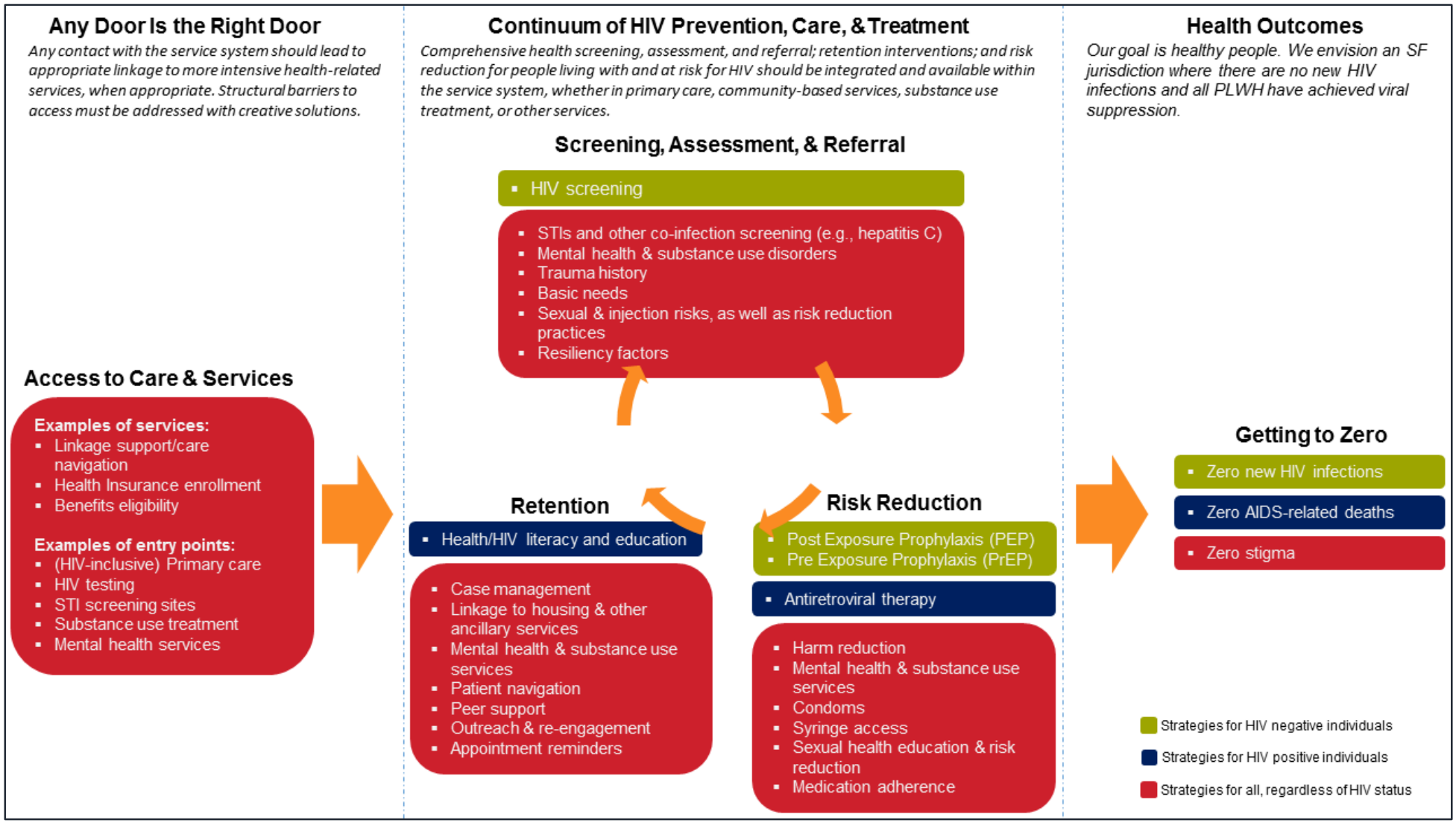
Annual targets will be set for each indicator, and data will be analyzed at least on an annual basis to assess progress. SFDPH will engage multiple stakeholders in this process, including community experts.

II. Overview of the San Francisco Jurisdiction's HIV Prevention Strategy

The Jurisdiction's HIV prevention strategy reflects a forward-thinking understanding of how to best meet the needs of people living with and at risk for HIV (PLWARH). The framework in Exhibit 5 moves beyond the concept of treatment as prevention and sees addressing HIV as a holistic health issue. It shows that prevention, care, and treatment are inextricably intertwined, and prioritizes the needs of people regardless of HIV status. In fact, the needs of PLWH and those at risk are no longer so different, a reality that presents inspiring opportunities for affected communities to come together around a common vision and set of priorities – ensuring access to health care and other services; providing a continuum of HIV prevention, care and treatment services using a holistic approach; and ultimately, as a result, getting to zero.

As of 2014, the Jurisdiction continues to implement and enhance the efforts outlined in the 2012 Plans, incorporating new HIV prevention science along the way. In addition, the implications of the Affordable Care Act (ACA) on HIV prevention are just beginning to be revealed, and we are continually adapting the Strategy as needed (e.g., leveraging third party payment for HIV and other disease screening).

Exhibit 5: San Francisco Jurisdiction Holistic Health Framework for HIV Prevention

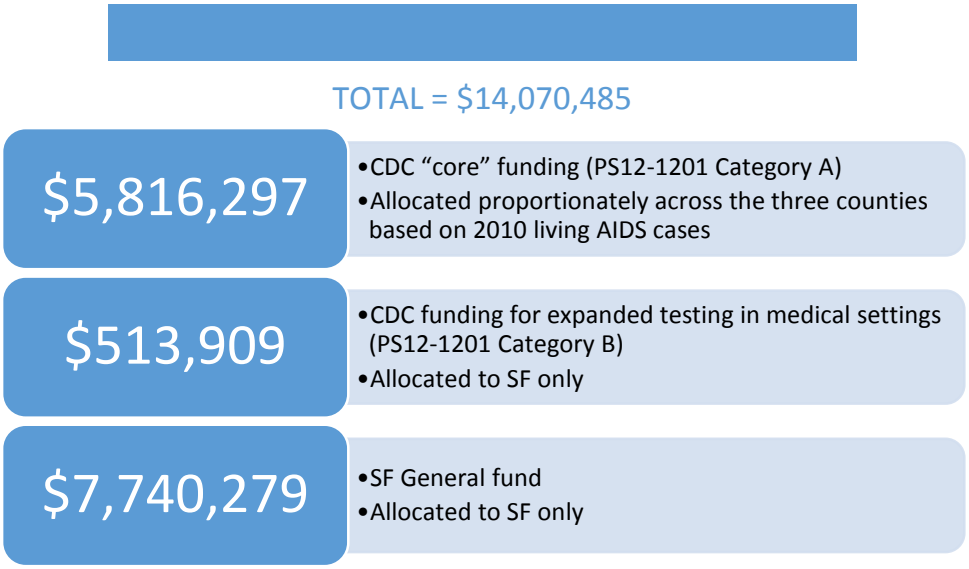


III. Resource Allocation

Overview of Resources

The SFDPH is the CDC grantee for the three-county jurisdiction. As of 2014, the SFDPH allocates approximately $14.1 million to support HIV prevention efforts in the jurisdiction (Exhibit 6).

Exhibit 6: SF Jurisdiction HIV Prevention Resources



Additional HIV prevention resources that are not included in this amount are:

- Approximately $1.7 million in CDC funding (PS12-1201 Category C) for the development of an integrated communicable disease data system (PHNIX)
- Non-PS-12-1201 sources of funding used by San Mateo and Marin counties
- CDC direct funding to community-based organizations (CBOs)
- Substance Abuse and Mental Health Services Administration (SAMHSA) HIV early intervention and Minority AIDS Initiative-Targeted Capacity Expansion (MAI-TCE) funding
- HRSA funds for HIV care and treatment
- HIV prevention-related research grants

Alignment of Resources with Local Epidemiology

Exhibits 7 and 8 depict resource allocation for 2014. Together, these two exhibits demonstrate that resources are aligned with the local epidemiology. Exhibit 7 shows how resources are aligned across the three counties in proportion to living HIV/AIDS cases. Exhibit 8 illustrates how SF City and County resources are allocated in accordance with SF's epidemiologic profile. (Note that San Mateo and Marin

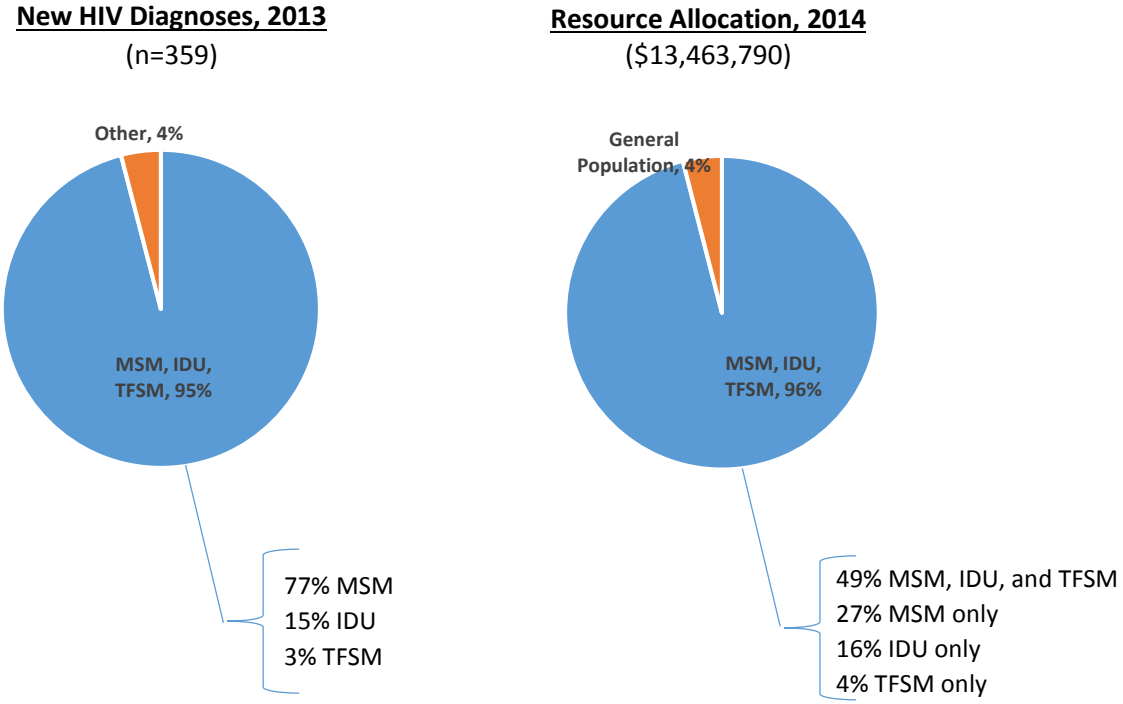
counties have separate funding allocation processes within their respective counties, which are not described here.)

Exhibit 7: Resource Allocation by County

County	Living HIV/AIDS Cases, 2013 **(n=17,890)**	PS12-1201 Category A Funds Allocated **($5,816,297)**
San Francisco	88.7%	89.6%
San Mateo	8.1%	7.1%
Marin	3.2%	3.4%
TOTAL	100.0%	100.0%

Exhibit 8: Epidemiologic Profile and Resource Allocation

City and County of San Francisco



Notes: Exhibit 8 represents the resources allocated for HIV prevention in the City and County of San Francisco using CDC funding from PS 12-1201 Parts A and B) and San Francisco General Fund support. For a description of the activities funded for each risk population shown in Exhibit 8, refer to the 2012 San Francisco Jurisdictional HIV Prevention Plan (pp. 30-32). "Other" in the new HIV diagnoses chart refers to heterosexual and unidentified cases.

IV. Access to Care and Services

HIV Testing

Data

Since 2012, the SF Jurisdiction has made great strides in expanding access to HIV testing. SF's increased focus on HIV testing has led to a steady increase in the numbers of tests performed, both in community and clinical settings, and the percentage of PLWH who do not know their status has dramatically decreased. San Mateo and Marin counties have also expanded access to testing through creative strategies, using the Internet and mobile services.

Core Activities Update

- SF continues to implement a two-faceted approach to expanding HIV testing and improving diagnosis rates: 1) increase community-based testing targeting high-prevalence populations (MSM, TFSM, and IDU), including acute infection detection; and 2) expand HIV testing in SFDPH medical settings using a variety of strategies (e.g., clinician champions, continuous quality improvement).
- In October 2012, San Mateo County launched an Internet outreach strategy to better reach MSM with information about HIV/STI resources. This strategy utilizes Grindr, a popular geosocial networking mobile application geared towards MSM, as a platform for health education. Health educators are available as general members on the application and offer information and resources to members who initiate contact with them. In Phase 1, October 2011 to March 2013, health educators reached 365 MSM contacts on Grindr, 79% of whom continued to engage in conversation after Health Educators identified themselves. In Phase 2, October 2013 to March 2014, health educators reached 816 MSM contacts of whom 70% remained engaged, and 113 specimens were tested for STIs/HIV with a 5.3% seropositivity including 1 new HIV case. All new HIV/STI cases were linked to care and treatment. San Mateo County has seen a 15-fold improvement in its number of MSM contacts with the addition of Internet outreach compared with traditional street outreach-only methods.
- In 2012, San Mateo County began efforts to implement CDC recommendations for routine HIV testing in primary care clinics. The County has developed a webpage with information and resources for providers; provides assistance with disclosure to HIV-positive patients, linkage and retention in HIV primary care; posts alerts and reminders via electronic medical records; and disseminates Greater Than AIDS campaign posters for display in health clinic waiting rooms and exam rooms. County clinics have had a 60% increase in HIV tests in the first half of 2014 compared to the same period in 2013, and a 72% increase in HIV tests compared to 2012.
- With very few resources for HIV prevention, Marin County conducts targeted HIV testing focusing on MSM, IDU, MSM-IDU, and African American and Latino first time testers. In addition to testing available on site at Marin AIDS Project, the County has adopted San Mateo County's Grindr intervention, conducts social network testing, and operates a rapid response phone line that people can call to request an HIV test. This increased targeting has been successful at identifying new positives.
- All three counties have implemented the Greater Than AIDS campaign to promote HIV testing.

- The Jurisdiction continues to explore and implement integrated disease screening (HIV, STI, hepatitis C) efforts.

Future Efforts

Planning

- Revisit SF's HIV testing strategy, messaging, and resource allocation, given the very low rate of undiagnosed HIV in SF (6.4%). Providers have hypothesized that SF has reached a state of "testing saturation," in which those continuing to test are relatively low-risk repeat testers. New approaches may be needed to reach the 6.4%, with an acknowledgment that this will require increased effort and resources with a lower yield. The following specific issues should be considered:
    - Recent estimates suggest that that 39% of new infections among MSM in the U.S. were transmitted between main partners (Goodreau et al 2012). Expansion of Couples HIV Counseling and Testing (CHCT) should be explored (Stephenson et al 2014).
    - Integrated services may reach those who wouldn't seek an HIV test (e.g., blood pressure screening, flu vaccines), and HIV testing could be offered in conjunction.
    - Anecdotally, the local HIV testing guidelines (all high-prevalence populations should test at least every 6 months) result in a high volume of lower-risk testers, perhaps at the expense of reaching the 6.4% undiagnosed.
    - Revisit and possibly revise SF's goal of providing 30,000 community-based tests annually.
- To promote a holistic health and wellness approach, explore the feasibility of integrating chronic disease prevention efforts into HIV programs (e.g., offering blood pressure screening at HIV prevention CBOs). Analyze data on underlying causes of death in PLWH (e.g., heart disease) to prioritize health screening services for various populations.
- Develop messaging to promote HIV testing at health care providers, while continuing to allow community-based options (in order to address stigma and increase convenience).
- Solicit community input in the scale-up of CHCT programs at community-based testing sites.
- HIV testing is an access point for entry into all types of services. The Jurisdiction plans to develop improved protocols and referral resources for linkage to housing, mental health, substance use, and other ancillary services. Such protocols should be designed to remove or mitigate barriers to access (e.g., excessive paperwork, challenges navigating complex systems).

Implementation

- SFDPH will implement Determine Combo, the new 4th generation rapid HIV test, in late 2014/early 2015. San Mateo and Marin counties are currently exploring the feasibility of implementing the new test.
- SFDPH will hire a Viral Hepatitis Coordinator to promote the integration of hepatitis C, HIV, and STI testing, and to oversee the local rollout of the CDC Hepatitis C social marketing campaign.
- The SFDPH Disease Control & Prevention Branch will work with the SFDPH billing department to maximize 3rd party billing for HIV testing in SFDPH medical settings.
- San Mateo County will expand its Greater Than AIDS campaign in late 2014 to encourage HIV testing.
- Marin County will explore how to work with medical settings to increase clinic-based HIV testing. Barriers include providers not feeling equipped to deliver HIV-positive results.

- SFDPH will work with community-based testing providers to implement new strategies for increasing HIV testing among IDUs to address high rates of undiagnosed infections, including use of incentives and linking hepatitis C testing with HIV testing.

Linkage to care and partner services

Data

Rates of initial linkage to care within 6 months of diagnosis have remained high and stable in recent years across the three counties – 85-90% in SF (SFDPH 2012), and 90-100% in Marin (special data request, July 2014). In 2013, 67% (n=285) of individuals newly diagnosed at funded testing locations were interviewed for partner services in conjunction with linkage support (Sachdev 2014). In 2013, SF's partner services program resulted in identifying 18 new HIV cases (Sachdev 2014).

Core Activities Update

- The SF Jurisdiction continues to provide support for initial linkage to care for all newly diagnosed individuals. In SF, this is done primarily through two programs, which coordinate with each other: 1) PHAST (Positive Health Access to Services and Treatment), which links patients diagnosed at SF General Hospital (SFGH), and 2) LINCS (Linkage Integration Navigation Comprehensive Services), which serves those diagnosed in community settings and medical settings other than SFGH. In Marin County, linkage rates are very high because there are usually fewer than 20 cases, and many if not most of those diagnosed already have primary care homes (e.g., Kaiser). San Mateo data pending
- San Mateo County utilizes an HIV Disease Investigator to provide facilitated linkage to care for individuals newly diagnosed with HIV and individuals who have fallen out of care. Activities include disclosure to individuals newly diagnosed with HIV throughout the Health System, partner services, prevention with positives, appointment reminders and check-ins, and escorts to first three visits or three visits after retention. The HIV Disease Investigator also cross-references new STI cases with HIV data to identify individuals who have fallen out of care.
- SF and Alameda counties have established a Memorandum of Understanding (MOU) to share data on newly diagnosed individuals who test HIV-positive in one county but live in the other county, to ensure that these patients do not "fall through the cracks" during the linkage process.
- As of 2014, SF is in the process of developing an integrated data system called PHNIX (Public Health Network Information Exchange). Among other functions, this system will integrate HIV testing, linkage, and partner services data, which will streamline and expedite linkage to care processes.
- Utilization of partner services has improved in SF since the advent of the LINCS Program, which pairs partner services with the linkage to care process.

Future Efforts

- Review best practices and local pilot programs that link newly diagnosed clients to same-day treatment, and assess whether such "red carpet entry" or "rapid treatment" programs should

become standard of care. If these are implemented, address provider-level barriers to same-day treatment (e.g., not enough time to assess patient readiness [DeMicco et al 2014]).

- Develop appropriate cross-county MOUs within the Jurisdiction for addressing linkage to care, similar to the MOU between SF and Alameda counties.
- Adopt consistent definitions and measurement for linkage to care that can be used to measure linkage rates over time.
- Enhance service system capacity to address substance use and mental health disorders, which could represent barriers to linkage. This might include expanding staffing for successful linkage programs to enhance their capacity for case management and mental health/substance use interventions.
- Address barriers to evening, night, and weekend linkage services.
- Develop and implement county linkage plans that include non-DPH providers, so that all medical and non-medical sites conducting HIV testing have protocols for immediate linkage to care.
- Consider the role of peer health educators/linkage experts within the broader service system in supporting linkage to and retention in care.
- Train linkage staff to be eligibility/enrollment workers to facilitate access to health coverage.

V: Continuum of Care

Screening, Assessment, and Linkage

Background

In keeping with a holistic approach to health, an important goal for the Jurisdiction is to ensure that HIV-affected communities receive regular and appropriate screening, assessment, and referral for health and social services needs, regardless of whether their entry point into services is via primary care, community-based HIV/STI testing, housing services, substance use treatment, or any other type of health or social service. Achieving this goal requires data-informed and strategic approaches to service integration (described later).

"**Screening"** includes testing for the presence of asymptomatic infections, as well as the identification of behavioral health needs and risk factors (e.g., substance use, mental illness, sexual risk, injection risk) and basic needs. **"Assessment"** refers to a more in-depth evaluation that confirms the presence of a problem, determines its severity, and specifies intervention or treatment options for addressing the problem. "**Linkage"** is the process of connecting a client from one service, provider, or service system to another.

Core Activities Update

- SFDPH is implementing locally developed integrated screening and vaccination guidelines (http://www.publichealthreports.org/issueopen.cfm?articleID=3113) addressing HIV, STIs, viral hepatitis, and tuberculosis.
- SFDPH has completed development of a set of recommendations for implementing an HIV-informed primary care behavioral health model, endorsed by the HPPC in August 2014. The document, entitled "Addressing the Behavioral Health Needs of People Living with and At Risk for HIV in Primary Care Settings: Recommendations for an Integrated HIV-Informed Primary Care Behavioral Health Model," will be presented to SFDPH decision makers in 2014-2015 to begin implementation. Key recommendations include ensuring appropriate sexual health and behavioral health screening in primary care settings.
- A number of program models have emerged that take a holistic approach to health and wellness for the target population, and include screening, assessment, and linkage to services either within or outside the program. This is the vision behind 474 Castro—a center for health and wellness for gay and bisexual men operated by the San Francisco AIDS Foundation and scheduled to open in late 2014 or early 2015.

Future Efforts

- Develop and implement a standard HIV curriculum for substance use and mental health providers, including culturally competent approaches for screening for HIV risk and referral and linkage resources.

- Implement the HIV-informed primary care behavioral health model recommendations, referenced above, which include expanding behavioral health screening, assessment, and linkage for PLWARH.
- Develop a mechanism, such as an interactive web-based tool, for health care providers to implement the SFDPH integrated screening/vaccination guidelines. Such a tool would allow the provider to enter patient demographics and the tool would show which screenings are clinically indicated.

Risk Reduction

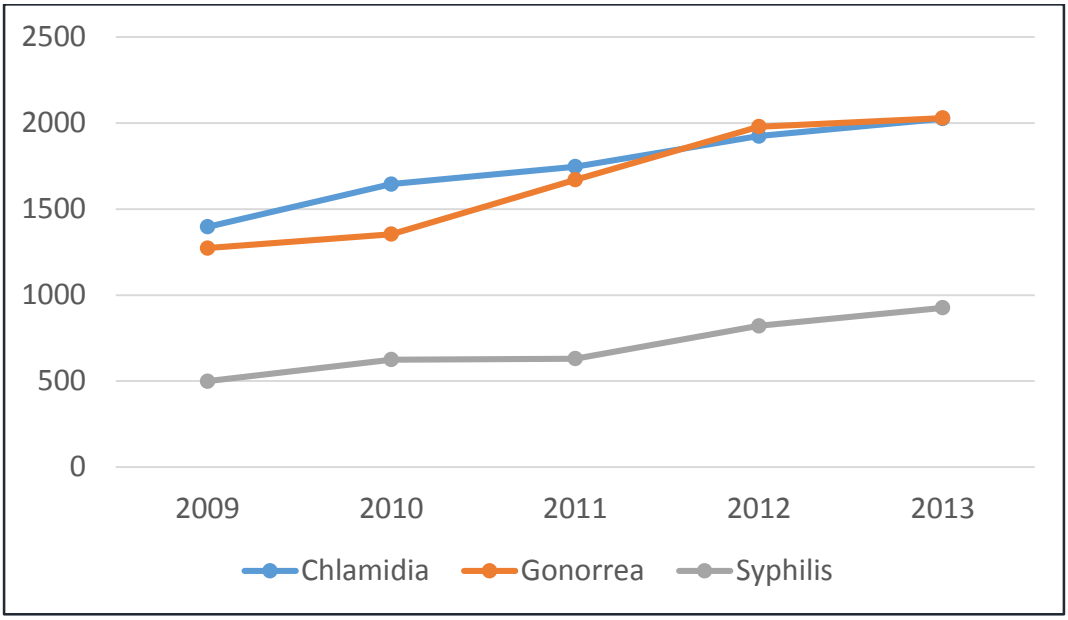
Background and Data

We are fortunate in 2014 to have a vast array of risk reduction tools at our disposal. We believe that, along with increased testing and access to treatment, the availability of such a wide variety of risk reduction strategies has contributed to the decline in new HIV infections. However, with still more than 300 new infections each year, it is critical to assess which particular factors are continuing to fuel the local HIV endemic. In SF's 2012 Jurisdictional Plan, six "drivers" of new HIV infections were identified (methamphetamine use, crack/cocaine use, poppers use, heavy alcohol use, gonorrhea, and multiple partners). In 2014, SFDPH will conduct qualitative interviews with acutely and newly infected individuals to assess the contextual factors that may have contributed to their HIV infection. The findings will be used to inform future HIV prevention priorities.

A recent trend of increasing STI rates among MSM in SF is of great concern (Exhibit 9). Some have questioned if HIV treatment and PrEP may be leading to reduced condom use and thus increases in STIs, but data from the iPrEx OLE study presented at the 2014 International AIDS Conference did not show risk compensation among PrEP users. Focus groups are planned to assess perceptions among MSM of STIs and how HIV and STI prevention messaging might need to change in the era of treatment as prevention.

Finally, it should be noted that there are disparities in access to risk reduction information and tools, including issues such as stigma, language barriers, socioeconomic status, health insurance status, and many others. The Jurisdiction will continue to work to remove all possible barriers to access.

Exhibit 9: Trends in Chlamydia, Gonorrhea, and Early Syphilis Among MSM
City and County of San Francisco
Source: Special data request, SFDPH, September 2014



Core Activities Update and Future Efforts

The following sections describe our current and proposed future activities for each risk reduction tool. These interventions exist along a behavioral/biomedical continuum. It is a false dichotomy to categorize these interventions as those that are considered "behavioral" and those that are considered "biomedical," since adhering to a treatment regimen might require behavioral support in the same way that safer sex or safer injecting behavior requires support. Furthermore, PLWARH often integrate both types of strategies into their personal HIV and STI prevention risk reduction plans, based on what works best for them and their life circumstances. In this spirit, we list these interventions alphabetically and not by priority or type of intervention. Finally, we know that substance use and mental illness can have a significant impact on HIV risk and on overall health. Therefore, mental health, substance use, and harm reduction interventions are included in this list.

CONDOMS

Starting in 2014, SFDPH will begin working with community partners to update condom messaging, in light of the advent of PrEP and the rise in STI rates. New messages should focus on overall sexual health, and include condoms as one of many tools in the risk reduction toolbox.

Core Activities Update

- In 2012 the SFDPH worked with the Police Department and community groups providing prevention services to sex workers to discuss changes to policies around the use of condoms as evidence in solicitation cases. This resulted in the development of a new policy in 2013 that prohibits condoms being used as evidence to prosecute sex work and will ultimately increase the number of sex workers who use condoms.

- The SFDPH has increased access to free condoms by establishing a sustainable female condom (FC2) program in SF. Funding from the MAC AIDS Foundation supported the costs of FC2s to provide them to agencies and local businesses interested in providing FC2 to their clients. SFDPH implemented trainings on their use among consumers as well as agencies and businesses. SFDPH also incorporated the FC2 into the longstanding community Condom Distribution Program. HIV service providers are also advised to include FC2s as a line item within their budget. Availability of free FC2's ended in October 2013 but trainings are available upon request.
- SFDPH continues to require all funded HIV prevention programs and the Ryan White Centers of Excellence to make condoms available to their program participants.
- In 2013, the SFDPH distributed approximately 1,548,502 condoms to approximately 200 venues (including high schools, SFDPH-funded sites, CBOs, and other nonprofit organizations).

Future Efforts

- SFDPH will engage in conversations with local businesses to explore their willingness in participating in the Condom Access Program as an effort to increase the availability of free condoms to SF residents.
- Availability of staff time has delayed SF's implementation of a citywide dispenser program accompanied by a campaign to promote condoms. An implementation plan for the citywide condom dispenser program will be developed and the SFDPH anticipates this program to be fully implemented in 2015.
- Address the impact of new attitudes and beliefs about condoms given the new prevention tools available (such as PrEP) – for example, those who continue to use condoms may experience stigma for being "out of date" in their prevention strategies or be labeled as someone who doesn't embrace their sexuality ("condom shame").

Mental Health and Substance Use Treatment and Prevention

Despite increasing attention on the role of substance use and mental health on HIV prevention outcomes, unmet needs remain. In fact, community-based providers in SF report that, over time, they are seeing increased service needs among clients. Local systemic issues and the policy environment (e.g., insurance restrictions on number of treatment sessions allowed) continue to hinder our ability to comprehensively address the needs of clients. The Jurisdiction has and will continue to promote a harm reduction, health-based (not criminalization) approach to behavioral health.

It is also important to continue to monitor drug use trends over time, to ensure that services are in line with community needs. Methamphetamine use among MSM in SF has declined since 2006, now steady at approximately 7% (NHBS data, 2013). However, poppers and cocaine use have increased steadily since 2009, at 35% and 20%, respectively, as of 2013 (NHBS data, 2013).

Core Activities Update

- In 2012, the SFDPH implemented the SAMHSA-funded Minority AIDS Initiatives-Targeted Capacity Expansion (MAI-TCE) program. This effort is a demonstration project to reduce health disparities and address needs of PLWARH affected by substance use and mental illness. The goal of MAI-TCE is to expand capacity to address behavioral health needs of PLWARH within primary care and other medical settings. Four behavioral health specialists embedded at different clinics in the city offer immediate access to behavioral health treatment with a focus on goal-oriented

treatment and linkages to other behavioral health services. By integrating behavioral health in primary care, the MAI-TCE project successfully:
    - Promotes early identification of treatment of mental illness, substance use, and co-occurring disorders by improving access to behavioral health services.
    - Enhances clinical practice.
    - Creates a cohesive service delivery system that supports better health outcomes.
- The MAI-TCE program collaborated with the HPPC to develop a set of recommendations to address the behavioral health needs of PLWARH in primary care settings. The recommendations address screening and testing, linkage and engagement, treatment approaches, coordinated and integrated care, training and capacity building, and continuous quality improvement. These recommendations were developed with the overarching purpose of:
    - Ensuring that the behavioral health needs of SFDPH clients living with and at risk for HIV are met through their primary care home.
    - Promoting sustainable, system-level changes resulting in improvements in the health and well-being of PLWARH.
- The 2014 HPPC Substance Use Work Group is developing a set of recommendations focusing on local issues of harm reduction; HIV prevention, treatment, and substance use system of care improvements; and the effects of criminalization of behavioral health. The ultimate goal of this work group is to develop an updated harm reduction policy that will encourage the City and County of SF, with leadership from the SFDPH, to endorse the philosophy of substance use as a chronic health issue that demands a health care response.

Future Efforts

- Identify unmet needs of crack users and implement effective service engagement strategies.
- Continue support of substance use and behavioral health integration models in primary care settings.
- Bring the recommendations developed by the HPPC Behavioral Health Work Group to the appropriate stakeholders for implementation at a systems level.
- Align principles and philosophy of harm reduction across all substance use treatment, HIV prevention and HIV care programs in SF. This would not require that every program take a harm reduction approach, but rather that harm reduction-based services are available and accessible within the system.
- Revise SFDPH Harm Reduction Policy (as needed) to recommit, restate, and embrace the principles of harm reduction.
- Work with the SF Police Department (SFPD) to operationalize the “Statement of Support by Law Enforcement Agents for Harm Reduction and Related Policies for HIV Prevention” recently signed by SF Police Chief Gregory Suhr.
- Define specifically how funded agencies will be held accountable for implementing the SFDPH harm reduction policy and its principles, including standard performance measures, and assess training needs of SFDPH staff (e.g., contract development and contract monitoring staff).
- Cross-train HIV prevention/care and behavioral health providers.

Medications for Treatment of Substance Dependence

Medications such as bupenorphine and methadone (opioid replacement therapy) and naltrexone for opioid or alcohol dependence can play a critical role in HIV prevention. While the details are not

discussed in this plan, pharmaceutical approaches to substance use deserve to be mentioned as yet another tool in the HIV prevention toolbox.

Overdose Prevention

Going forward, the integration of overdose prevention with HIV prevention is a high priority for SF. Data suggest that the increasing availability of naloxone has greatly reduced overdose-related mortality in SF, and it is clear that naloxone should be made even more widely available.

Core Activities Update

- SFDPH supports the DOPE Project to distribute naloxone through multiple settings, including family support groups, county jail, health clinics, methadone maintenance, and syringe access and drug treatment programs.
- Naloxone is also available from the pharmacy at 1380 Howard Street for patients receiving methadone and bupenorphine, the South of Market Mental Health Clinic which provides naloxone kits directly to patients, pain patients at six SFDPH clinics, and from SFDPH nurses prescribing naloxone to single room occupancy (SRO) hotel residents.

Future Efforts

- Support outreach services and consider developing a culturally appropriate social media campaign to reinvigorate harm reduction approaches.
- Work with the SFPD to design and implement a naloxone program in which officers will carry naloxone and be trained to use it.

Post-Exposure Prophylaxis (PEP)

SFDPH continues to operate a large, well-established PEP program at City Clinic, the municipal STI clinic. PEP is also available in other SFDPH medical settings, as well as from private providers. The City Clinic program provides PEP to approximately 200-250 persons per year. Future priorities include assessing low-cost methods for expanding access to PEP in San Mateo and Marin counties. In addition, PEP is covered by most private insurers as well as Medi-Cal, and the Jurisdiction will seek to increase third party billing for PEP.

Pre-Exposure Prophylaxis (PrEP)

PrEP is far more available in 2014 than it was even one year ago. It is covered by most insurance plans, as well as Medi-Cal and Healthy SF. Much community dialogue is happening regarding PrEP, and information is widely available online. SFDPH is currently in the process of developing a comprehensive approach to supporting PrEP access and uptake.

Equity is a major concern. Populations most in need of PrEP may be the same populations that have the least access. Access issues go beyond ability to afford the medication. For example, the dearth of trans-friendly primary care providers restricts access for transgender women. HIV- and sexual orientation-related stigma and discrimination also might affect access.

PrEP is already dramatically altering the landscape of HIV prevention. Online hookup sites now include "HIV-negative on PrEP" as an option for HIV status. Unprotected sex and STI rates are increasing among

MSM (it is unclear whether PrEP is playing a role in this phenomenon). HIV prevention risk reduction messaging and interventions need to be re-invented. More than ever, holistic health and sexual health approaches are needed in this new era.

Future Efforts

- Consider if and how to redirect CDC and/or County General Funds toward PrEP-related activities (refer to CDC PrEP guidance letter dated May 14, 2014)
- Analyze data from the SFDPH Bridge HIV and Disease Prevention & Control Branch joint demonstration project at City Clinic and continue to conduct studies to determine how PrEP will work in the real world.
- Issue a statement on PrEP in 2014, supporting PrEP as another tool in the HIV prevention toolbox and signaling a coordinated approach to local rollout.
- Develop guidance for HIV prevention and other providers on PrEP messaging, referrals, and linkages.
- Educate medical providers on PrEP using public health detailing or other efforts and consider the development of an SFDPH PrEP clinical policy, using relevant policies as a model (e.g., SF's universal offer of treatment policy, Kaiser's PrEP policy).
- Expand access to PrEP for priority populations:
    - Identify and address barriers to access for gay men.
    - Based on focus groups and other data, SFDPH will develop a strategy for expanding education about and access to PrEP for transgender females. Any efforts to expand access must address primary care cultural competency.
    - Develop strategies for ensuring equal PrEP access for communities of color, non-English language speakers, and other populations with barriers to access.
- Research financing and insurance coverage of PrEP, develop pathways for PrEP access, and disseminate this information to communities.
- Provide leadership on standards regarding any adherence or behavioral counseling that should accompany PrEP provision.
- Address specific issues and concerns as they arise. For example, will youth on parents' insurance plans be less likely to access PrEP for fear of confidentiality breaches? Is there a need to educate substance use providers, who may see PrEP as a trigger for using because combining sex and substance use is thought to be no longer as risky when on PrEP?

Sexual Health Education/Risk Reduction

Sexual health education and risk reduction efforts must continue to evolve to meet changing needs. Broad sexual health frameworks that go beyond just HIV are needed. Integrated approaches – such as cardiovascular disease and HIV prevention education offered together – should be implemented when it makes sense based on the target population. Training for non-HIV program staff is essential so that PLWARH can access sexual health messages and interventions through any point of access. It is vital to consider how sexual health interventions should incorporate the continued movement towards increased online negotiation of sex, and the availability of individuals' HIV status, viral load, and PrEP use on hookup sites as tools for seroadaptation. Attention to the specific and evolving needs of subpopulations is also needed. For example, 1) older gay men may need something different than younger gay men, and 2) newcomers to the Bay Area (especially those from non-urban areas) need to know that the same behaviors in low-prevalence locations are more likely to result in HIV transmission in the Bay Area, where HIV prevalence is higher.

Core Activities Update

SFDPH continues to support several projects that incorporate sexual health education/risk reduction:

- Special Projects to Address HIV-Related Health Disparities (African-American MSM, Latino MSM, MSM, Transfemales) and Health Education/Risk Reduction Projects to Address Drivers provide their clients with information, resources, and prevention activities. These programs have a strong focus on components that address drivers, cofactors, contextual factors, and HIV risk behaviors, particularly unprotected anal sex, as well as promoting HIV testing and linkage to care.
- Community Health Equity & Promotion (CHE&P) Branch staff conduct sexual health services and events in the Bayview/Hunters Point area. These efforts are implemented to decrease the high levels of Chlamydia among young women. Activities include, outreach, information tables, and presentations at schools and CBOs. The goals of these efforts are to increase STI testing and provide culturally appropriate resources and referrals to youth specific services.
- The SFDPH and the HPPC are collaborating the Department of Health and Human Services Department (DHHS) efforts to develop guidelines for sexual health for gay men targeting clinicians and physicians. The guidelines will be distributed for community input.

Future Efforts

- Integrate risk reduction into non-HIV programs (e.g., substance use treatment) and provide appropriate staff training.
- Increase the online presence of sexual health education and risk reduction when appropriate, incorporating information about PrEP and other new developments.
- CHE&P Branch staff will conduct a series of youth-oriented focus groups to assess the sexual health education needs of the Bayview/Hunters Point community.
- SFDPH will work closely with programs that have expressed having "tapped" their pool of clients by providing technical assistance for increasing outreach efforts to reach new clients.
- Consider implementing an innovative mentoring program for young gay men and transfemales, to support the development of their personal strategies for sexual health.

Syringe Access and Disposal

Syringe access and disposal remains the cornerstone of HIV prevention efforts for IDUs in the Jurisdiction. In 2013, the SFDPH distributed 3,151,842 syringes, an increase from previous years.

Given that community-based syringe access programs are the primary mechanism we use to reach IDUs, there is an underutilized opportunity for expanding access to hepatitis C testing and linkage to care in these settings. Comprehensive planning to address hepatitis C in the Jurisdiction is underway.

Core Activities Update

- All three counties support syringe access and disposal services for IDUs using non-federal funds. In addition to community-based services, syringes can be purchased without a prescription at pharmacies in all three counties.
- SFDPH continues to expand collaborations with SFPD, drug treatment programs, community activists, and other city departments (e.g., Department of Public Works, or DPW) to implement innovative strategies for syringe access and disposal. For example, these partners have worked together to place syringe disposal boxes in strategic locations throughout the city, resulting in

24-hour access to safe syringe disposal and reduced or eliminated improperly discarded syringes found in these areas.

Future Efforts

- SF city dynamics are changing. Increases in construction and displacement of homeless people are resulting in increased complaints about discarded syringes. Disposal options we relied on previously are no longer sufficient and need to be expanded. The following efforts are high priority:
  - Increase sweeps by Syringe Access Collaborative providers and expand disposal options (e.g., boxes) in hot spot areas in SF.
  - Continue to coordinate efforts with other SF city and community partners doing syringe disposal. Meet with community groups, SFPD, and CBOs that have concerns about discarded syringes and develop a collaborative plan/next steps. Ensure that all stakeholders are informed about these collaborative efforts, including SFPD captains and Board of Supervisors representatives for hot spot neighborhoods.
  - Increase education efforts among IDUs on the available safe disposal options.
- Determine effective approaches for increasing HIV and hepatitis C testing at syringe exchange sites.

TRAUMA-INFORMED CARE

SFDPH's Trauma-informed Systems Initiative will provide training to all 7,000+ SFDPH staff. This approach shifts the question from "what's wrong with you" to "what happened to you" and will help build capacity within SFDPH for providing impactful health services. The vision is a trauma-informed system of care that acknowledges the impact of stress and trauma, particularly racism, on the workforce as well as the people we serve. (Source: Trauma-Informed Systems Initiative training presentation and curriculum outline).

Retention

Data

Marin County has very high HIV care retention rates because county staff are able to devote intensive individual attention to addressing patient needs, due to the low number of cases. In contrast, SF experiences significant challenges with retention, likely due to the high number of patients overall, and more specifically, the high number of patients with extreme barriers to engagement (e.g., multiply diagnosed). In 2012 in SF, although 89% of newly diagnosed individuals were linked to care within 3 months, only 64% were retained in care 3 to 6 months after initial linkage and only 51% were retained 6 to 12 months post-linkage (SFDPH 2013).

Core activities update

- In SF, most retention efforts continue to be operated out of the clinics and funded by sources other than HIV prevention dollars (e.g., Ryan White). HIV prevention's primary investment in this area is the LINCS program navigation services, which provide re-linkage to care for patients

who fall out of care. In 2013, 232 out of care patients were referred for LINCS navigation services, 127 (55%) of which were able to be located. Of those, 72 (31%) were re-linked to care within 90 days and 61 (26%) had a primary care visit and a viral load test within 90 days (Sachdev 2014).

- San Mateo County continues concerted retention efforts. If a patient falls out of care and is re-linked to care, the Disease Intervention Specialist care coordinator escorts patients to two appointments after re-linkage to promote ongoing retention. Patients who test positive for an STI, and who have HIV but have fallen out of care, are re-linked to care. This is made possible by an integrated HIV/STI data system with provider alerts.
- In Marin County, case managers and outreach staff provide ongoing retention support to patients (appointment reminders, etc.) resulting in high retention rates.
- SFDPH's HIV Epidemiology Section partnered with LINCS on the RSVP project, which uses surveillance data to identify and re-engage into care persons with HIV in the greater Bay Area with unsuppressed viral load who have fallen out of care.
- SF's MAI TCE Program promotes retention in primary care for people living with HIV as well as those at risk, by providing mental health and substance use screening, assessment, treatment, and linkage. These services help to reduce substance use and mental health-related barriers to care engagement.
- SFDPH's HIV Health Outreach Mobile Engagement (HHOME) Project, a Ryan White Special Project of National Significance (SPNS) funded from 2012 to 2017, is a mobile, multidisciplinary team-based intervention designed to engage and retain in care the most severely impacted and hardest-to-serve homeless persons living with HIV in SF. The goal is to increase the quality and length of life of multiply diagnosed persons living with HIV while reducing new HIV transmissions by engaging and retaining multiply diagnosed homeless persons with HIV in HIV medical care, housing, and behavioral health services. To date, HHOME has served 31 clients.
- SFDPH's TransAccess program, also a 5-year SPNS project, provides high-quality, neighborhood-based patient-centered medical home services for transgender women of color living with or at high risk for HIV infection. Services include HIV medical care, transgender health services (including hormone therapy), psychosocial (support including case management and Masters-level social work), and behavioral health (including psychotherapy and support groups). The goals are to enhance utilization of and retention in HIV medical care by underserved transgender women of color, and to diagnose and link those with unidentified HIV infection. It has been observed that it takes upwards of five different client encounters before linking a client to their initial appointment. Operating in an open-access model, opposed to appointment-only, has significantly increased the number of clients attending their appointments.

Future Efforts

- Expand navigation services in SF to focus on ongoing retention and not just re-linkage to care.
- Identify feasible and evidence-based retention strategies (e.g., text messaging appointment reminder services) and develop a plan for funding and implementing these efforts.
- Reframe the concept of retention as "preventing people from falling out of care." Develop indicators for who is at risk for falling out of care, and target services to those individuals.
- Consider mechanisms for engaging patients' families in retention efforts.

VII: Structural Approaches

The SFDPH and the HPPC recognize that to achieve lasting impact on trends in HIV, structural factors must be addressed. The following sections highlight a few of the many pressing issues facing us in 2014.

Stigma and Discrimination

Despite many positive advances in HIV prevention and treatment, HIV stigma and discrimination continue to profoundly influence health outcomes. HIV stigma and discrimination are known to negatively impact prevention behaviors, testing behaviors, treatment behaviors, emotional health, and mental health (Smit et al. 2012). Approaches to reduce HIV stigma and discrimination include:

- Informational/educational sessions about HIV for the HIV-negative community (Sengupta et al 2011)
- Counseling, support, and skill building around dealing with stigma and discrimination for the HIV-positive community (Sengupta et al 2011)
- Normalization of HIV and STI testing as a routine part of healthcare

In addition to general stigma and discrimination due to an HIV-positive status, some groups, including transgender persons, experience specific forms of stigma and discrimination that affect their healthcare experiences and health outcomes. The SFDPH recently revised their sex and gender guidelines for collecting, coding, and reporting identity data to accurately capture and recognize all sex and gender identities "that are meaningful for identifying differences in health outcomes, conditions that impact health, and delivery of health services" (http://www.sfdph.org/dph/files/PoliciesProcedures/COM5_SexGenderGuidelines.pdf). Transfemale and transmale identities are now captured in all SFDPH sex and gender questionnaires, allowing for more appropriate delivery of healthcare services for these populations.

As we plan for the future, it is imperative that we continue to develop focused efforts to address issues of HIV stigma and discrimination, considering both evidence-based practices and innovative approaches. This will include working across City Departments in all counties, as well as educating community-based providers on implementing programs free of HIV-related stigma.

Regional HIV Prevention Approaches to Address Mobility

Bay Area counties have a strong desire to collaborate with each other to provide a seamless continuum of HIV prevention, care, and treatment for affected populations. The lack of specific resources devoted to cross-county collaboration is a significant barrier to developing such a coordinated response.

One collaborative effort addresses HIV prevention around regional mobility of individuals living with HIV between SF and Alameda counties. An MOU) has been completed between the SFDPH and the Alameda

County Public Health Department (ACPHD) for designated staff to exchange case information of all "individuals with HIV infection or exposure requiring HIV public health services in one of these counties but residing in the other county, in accordance with California Health and Safety Code (HSC) 121025-121035." In the future, we will explore the development of such MOUs Jurisdiction-wide.

Changing Demographics and Income Disparities: New Challenges for HIV Prevention

The SFDPH recognizes that SF is experiencing significant challenges with regards to increasing cost of housing, widening income disparities, homelessness, and health disparities. Tensions have arisen in some neighborhoods where expensive housing is located near homeless encampments or services for marginalized populations (e.g., mental health treatment programs, syringe access sites). In addition, providers report displacement of some of their clients, who have been forced out of the city due to rising housing costs. This can be extremely disruptive to care for HIV-positive individuals in particular.

The multiply diagnosed, homeless and marginally housed population is very visible in SF, leading to renewed leadership to address these severe need populations. One effort is the development of the Mayor's CARES Task Force. The Task Force's final recommendations include: increase opportunities for family member involvement in care, increase the use of peer specialists to engage and retain members of this population in care, advocate for policy changes that work to support the success of members of this population, create and expand programs to ensure that members of this population are placed in the most appropriate levels of care that support their recovery and success, and facilitate information sharing among care providers to promote a collaborative and coordinated care approach.

SFDPH also has devoted significant staff time to working with neighborhood residents and SFPD to address concerns related to discarded syringes, homelessness, and drug use in ways that can meet everyone's needs.

While SFDPH cannot change the city's trajectory, future efforts will consider if and how the SFDPH can play a role in educating newer San Franciscans about the importance of public health and other services for these populations, and engage these communities in solution-oriented dialogue. One idea is to engage the tech companies, which employ a large subset of new SF residents, and make them allies in the effort.

Affordable Care Act

The SF Jurisdiction has engaged in various efforts to address the impact of the Affordable Care Act (ACA) on HIV prevention. One effort is the formation of the SF Health Care Reform Task Force (HCRTF), formed in late 2012 under the mission statement: "To plan for the secure and safe transition of San Franciscans –living with HIV and HIV prevention and care providers –from currently funded HIV care and prevention services into broader systems of care while retaining comprehensive, quality and co-located prevention and care services" (http://www.sfhiv.org/community-planning/hiv-healthcare-reform-task-force/). The Task Force's planning process focused on developing recommendations for a successful transition plan that fills gaps in service eligibility, affordability, and scope of benefit, prepares community-based HIV

health service providers to plan for financial changes and comprehensively integrate into broader healthcare systems, and prepares broader healthcare systems to handle the integration of high-utilization, high-cost HIV clients into care.

Another major effort is the PS12-1201 Category B: Expanded HIV Testing Program Redirection for Billing and Reimbursement. The goal of this redirection plan is to increase local capacity to seek reimbursement for HIV testing and other services covered by private health insurance, Medicare and Medicaid or other third-party payors.

While ACA has greatly improved access to health insurance for previously uninsured populations, undocumented immigrants continue to have challenges accessing regular health care due to ineligibility for insurance programs. Health care costs can be covered with local funding, but this is not a sustainable solution, nor does it address the multiple barriers to care this population faces (e.g., health care and information not easily accessible in primary language, fear of accessing services due to illegal status). Specialized efforts are needed to ensure health equity for this population.

Finally, implementation of ACA is proving to be an extremely complex in the already fragmented and multi-layered care systems in SF. Resolution of eligibility challenges (e.g., re-eligibilizing individuals on a regular basis may disrupt care if they are on the border of Medi-Cal eligibility, incarceration can destabilize access to health coverage), increased capacity of facilities to accept all types of insurance, and training for clinic staff are needed to move forward.

Leveraging Data to Maximize Health Outcomes

SF City and County in particular has a wealth of HIV-related data to draw on when making decisions about resource allocation and program development. Data-driven decision-making has long been a fundamental tenet for HIV prevention in SF. The biggest challenge facing us in 2014 is how to coordinate, streamline, and leverage data in real time (or as close as possible) for public health action. Fragmented data systems create missed opportunities for intervention. For example, in SF, if a patient who has fallen out of HIV care accesses STI testing in the community, the STI provider would not necessarily know the person's HIV status or that s/he was out of care, resulting in a missed opportunity to re-link to care.

San Mateo County is a model for using integrated HIV/STI data to drive public health action, and SF is taking steps toward data integration. SFDPH is in the process of developing an integrated data system called Population Health Network Information Exchange (PHNIX). One of the goals is to allow real-time identification of public health action opportunities so that SFDPH and CBO staff can provide appropriate interventions. PHNIX will help improve HIV test results disclosure, linkage to care, partner services, and re-linkage for out of care patients, as well as STI, hepatitis, and tuberculosis services and outcomes. The HIV module for PHNIX is scheduled to be available in early 2015.

An area in great need of additional exploration is identifying and gathering common core data elements across the Jurisdiction that are feasible, given the limited data resources and infrastructure in San Mateo and Marin counties.

Service Integration and Coordination

The term “integration” has many meanings, but ultimately, its goal is to make it possible for individuals to get what they need, when they need it, with respect to their health. In many cases, achieving this goal requires significant transformations in systems, structures, and operations. A few examples of prioritized integration efforts for SFDPH are as follows:

- Reorganization of both the population health and health care delivery functions of the SFDPH (2013-2014), and an accompanying larger “systems planning” effort to align community-based services with ACA.
- Efforts toward integrated HIV prevention and care community planning (see below).
- Scale-up and integration of hepatitis C testing, linkage, and treatment into HIV and other services (including addressing the challenges of access to treatment due to its high cost). The Jurisdiction plans to launch CDC’s viral hepatitis social marketing campaign locally in 2014/2015, and SFDPH plans to hire a Viral Hepatitis Coordinator.
- Training on integrated models for substance use, HIV, and hepatitis C (provided by AETC). Marin County staff completed this training and plans to train SFDPH staff are in progress.
- Integration of HIV prevention with broader, population-specific culturally competent health and social services. This is especially important for the transgender community. The SF Transgender Advisory Group recommends “one-stop shopping” for services ranging from trans-specific substance use/mental health services to education and employment assistance to primary care services. The services should focus on health and wellness, not on HIV.
- Increase coordination and collaboration with non-HIV efforts such as structural interventions to address alcohol use and cardiovascular disease prevention to improve overall health outcomes.
- Identify and expand/replicate integration best practices. One example is the HIV & Integrated Services program (formerly Forensic AIDS Project) operating in the SF jail system. In collaboration with SFDPH STD Prevention & Control Program, the Linkages to Health Education and Prevention (LHEAP) team offers HIV, STI and hepatitis C testing to SF residents upon entry into the SF county jails. In 2013, over 3,000 people were tested for HIV, 24 positives were identified of whom 12 were new diagnoses. Ten of the newly diagnosed (83%) and 7 of the known HIV-positive individuals (58%) were linked to care. In addition, overdose prevention is also integrated. In 2012, the LHEAP team in collaboration with the DOPE Project implemented a pilot project to make the naloxone nasal spray available upon release to individuals who participate in a brief training.
- Future consideration of issuing requests for proposals (RFPs) that leverage different funding streams for integrated services.
- Dialogue about how to better integrate data and data systems for improving health services and outcomes (see previous section).

It is important to note that service integration may offer some solutions to challenges that HIV prevention has long faced. Historically, HIV prevention has been asked to fund services for populations at high risk for a variety of health issues, even though risk for HIV may be low. For example, it is not uncommon to hear that services for non-MSM populations, such as HIV-negative women and non-MSM youth, are insufficient. Integration offers opportunities to fund services appropriately, while also meeting the need (e.g., integrating HIV prevention messages into homeless services at low or no cost). The HIV prevention and sexual health needs in Bayview/Hunters Point, which is home to many HIV care and treatment services but few HIV prevention services, can be addressed by leveraging non-HIV-related efforts and broader health initiatives (e.g., SFDPH’s African American Health Initiative). Finally, in the process of “getting to zero” the target population will be harder and harder to reach. Integrated services where HIV is not the focus might attract clients that we haven’t been able to reach in any other way.

VII: Next Steps

How This Plan Update Was Developed

Community engagement is an important piece in the planning of our local HIV prevention, treatment and care efforts. As a way to keep our finger on the pulse of the community, several meetings were implemented in the Spring and Summer of 2014 to inform the development of this update to the Jurisdictional Plan. During these meetings members of the HPPC, community at large, and other stakeholders received a series of opportunities to participate in a discussion about HIV prevention priorities and provide input on the narrative for the strategy. These input meetings included:

- HPPC meeting to update to full Council on the Jurisdictional Plan Work Group on May 8
- HPPC Jurisdictional Plan Work Group
- Input session with SFDPH Population Health Division and HIV Health Services staff on July 1 and 8
- HIV Testing Coordinators meeting on July 11
- HIV Health Services Planning Council invited to Jurisdictional Plan Work Group meeting on July 15
- HIV Prevention Providers meeting on July 21
- Transgender Advisory Group meeting on July 22
- Draft sent to HIV/AIDS Providers Network for comments on July 30
- HPPC meeting to present for Concurrence on August 14

These opportunities for feedback demonstrate the effective and ongoing partnership between the SFDPH, community planning groups and stakeholders. The final update to the Jurisdictional Plan was discussed at the full Council meeting in August 14. A motion for concurrence was made, seconded and approved by the membership.

Next Steps

During 2013, the SF HIV Prevention Planning Council (HPPC) and HIV Health Services Planning Council (HHSPC) formed a Collaborative Planning Work Group to develop a plan for integrated HIV prevention and care planning. SFDPH retained a consultant to facilitate the work group, which met six times during the reporting period. The Work Group developed a preliminary recommendation for integrated planning. In October 2013, the motion to adopt the recommended model of integration was approved by the HPPC, however, the HHSPC voted not to approve the motion.

The announcement of the release of CDC and HRSA new integrated community planning guidance by Spring of 2015 ignited the need for leadership from the HPPC and HHSPC to engage in conversations regarding the future of collaborative local HIV prevention, treatment and care planning. For the past few months leadership from both Councils have been holding regular meetings with the goal of identifying next steps in collaboration. Since 2012 the HPPC has invited the HHSPC to participate in the development of our Jurisdictional Plan.

Co-chairs from both the HPPC and HHSPC have been meeting monthly since May of 2014 to outline a shared vision and plan for future collaboration. The first charge of this group is to convene a transition

team in January of 2015. The goal of the transition team is to draft the scope of work for a joint leadership committee which finally will develop implementation plans for a merged Council reflective of the local priorities and national policy.

VIII: Conclusion

This update to the Jurisdictional Plan illustrates the success of HIV prevention efforts in SF, San Mateo, and Marin counties. The strategies presented in this plan reinforce our commitment to eliminating HIV-related health disparities within the Jurisdiction. Our goal remains to keep those individuals not living with HIV from becoming infected, those newly diagnosed linked to care and treatment, and those out of care linked or re-engaged into care and treatment. In other words, our goal is to have healthy people. By ensuring health and well-being for all Jurisdiction residents, we believe we can actualize the "getting to zero" vision - zero new infections, and zero AIDS-related deaths, and zero stigma.

This vision would not be possible without the effective and ongoing partnerships among the SF, San Mateo, and Marin County health departments; other city/county departments such as the SFPD; the HIV Prevention and Health Services Planning Councils; community-based providers; researchers; clinicians; and many others. Community engagement of all stakeholders will always play an integral role in the planning of our local HIV prevention, treatment, and care efforts.

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List of Acronyms

ACA	Affordable Care Act
ACPHD	Alameda County Public Health Department
AETC	AIDS Education and Training Centers
AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CHCT	Couples HIV Counseling and Testing
CHE&P	Community Health Equity & Promotion
DPH	Department of Public Health
DPW	Department of Public Works
ECHPP	Enhanced Comprehensive HIV Prevention Planning
FOA	Funding Opportunity Announcement
HIV	Human Immunodeficiency Virus
HPPC	HIV Prevention Planning Council
HRSA	Health Resources and Services Administration
IDU	Injection Drug User
LHEAP	Linkages to Health Education and Prevention
LINCS	Linkage Integration Navigation Comprehensive Services
MAI-TCE	Minority AIDS Initiatives-Targeted Capacity Expansion
MOU	Memorandum of Understanding
MSA	Metropolitan Statistical Area
MSM	Men who have Sex with Men
MSM-IDU	Men who have Sex with Men and are Injection Drug Users
NHAS	National HIV/AIDS Strategy
NHBS	National HIV Behavioral Surveillance
PEP	Post-Exposure Prophylaxis
PHAST	Positive Health Access to Services and Treatment
PHNIX	Public Health Network Information Exchange
PLWARH	People Living with and at Risk for HIV
PLWH	People Living with HIV
PrEP	Pre-Exposure Prophylaxis
RFP	Request for Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SFDPH	San Francisco Department of Public Health
SFGH	San Francisco General Hospital
SFPD	San Francisco Police Department
SPNS	Special Project of National Significance
SRO	Single Room Occupancy
STD/STI	Sexually Transmitted Disease/ Sexually Transmitted Infection
TFSM	Transfemales who have Sex with Men

Community Health Equity & Promotion Branch

POPULATION HEALTH DIVISION

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH