

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

A collaboration of the HIV Prevention Planning Council (HPPC), the San Francisco Department of Public Health (SFDPH), San Mateo County and Marin County

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I. 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. 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.

San Francisco has always embraced a community focused response to meeting the challenges of the HIV/AIDS epidemic, engaging multiple stakeholders in the design and implementation of HIV prevention efforts. There is a new sense of hope as new and effective tools are introduced that have remarkable potential. But our belief in collective action has never been stronger. The principles of collective impact (Kania 2011) – the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem – is providing a framework for bringing together HIV prevention providers, policy makers and community members with the HIV care community and its vast experience working with People Living With HIV (PLWH) to create a seamless and dynamic response to realizing our goal of ending the epidemic in our lifetime.

This is the second update to “The Jurisdictional HIV Prevention Plans for the San Francisco MSA, 2012-2016” and continues to highlight successes to date, provides current progress on new initiatives outlined in the 2014 Update and continues to examine 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.

Organization of the Strategy

The Update to the Jurisdictional HIV Prevention Plans for the City and County of San Francisco, San Mateo County, and Marin County (known as the “Strategy”) is a comprehensive review of ongoing and future efforts being implemented and planned across the region. Throughout this document, “Jurisdiction” refers to those efforts that include all three counties. Each section identifies core activities and future efforts for each county individually and for the jurisdiction overall.

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 the 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.

Getting to Zero

San Francisco's Getting to Zero (G2Z) initiative (www.gettingtozeroSF.org) is a multi-sector independent consortium operating under the principles of collective impact. The initiative has three goals: 1) zero new infections, 2) zero deaths, and 3) zero stigma. Modeled after the UNAIDS goals, the vision of G2Z is to reduce HIV transmission and HIV related deaths in San Francisco by 90% from their current levels before 2020. The G2Z strategic priorities describe a comprehensive approach with three signature initiatives:

√ PrEP Expansion

√ Provision of antiretroviral therapy in the setting of acute HIV infection or upon diagnosis

√ Retention in HIV care

The Getting to Zero Consortium work is done in committees, which are lead by co-chairs and a liaison from the Steering Committee. Each committee is charged with defining measurable objectives and a program implementation plan. Under the direction of a Steering Committee and with broad partnerships with community organizations and the private sector, the Consortium is an active process, engaged through committee work and program implementation to achieve the Getting to Zero goals.

Steering Committee

Strategic direction to the vision and funding of Getting to Zero Initiatives

The steering committee provides strategic direction to the vision and funding of Getting to Zero initiatives. Members of the steering committee prioritize the goals of Getting to Zero and do not act on behalf of their agencies in this leadership role.

The overall goal of the RAPID (Rapid ART Program Initiative for HIV Diagnoses) program will be to create a set of "hubs" around the city where persons newly diagnosed with HIV (or out of care) can rapidly access antiretroviral therapy (ART) and have a smooth transition to their continuity of care clinic.

RAPID Committee

Support for persons newly diagnosed with HIV

Retention Committee

Engaging those living with HIV in high quality care

The goal of this initiative is to develop systems and programs to increase retention and re-engagement in care, and viral suppression among those living with HIV resulting in people living long and healthy lives.

The PrEP initiative has 3 core components focused on providers, users, and measuring impact. A PrEP steering committee oversee efforts in these 3 areas:

- √ Improved user knowledge and access
- √ Increased provider capacity
- √ Tracking PrEP uptake and impact

PrEP Committee

Reducing HIV transmission

Ending Stigma Committee

Reducing HIV related stigma

Reducing HIV related stigma is a critical component of realizing the goals of all Getting to Zero committees. The Getting to Zero Ending Stigma committee launched in May 2015 and is charged with creating measurable objectives and defining the areas for change.

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).

The downward trend observed in the 2014 update is continuing and while we are still cautious, our optimism has strengthened as we see the goals of getting to zero within reach. The clear link between the Jurisdiction's community engagement approach, combined with rapid implementation of new scientific advances, and decreases in HIV incidence is stronger than ever.

These combined efforts have led to the lowest rate of undiagnosed HIV infection in the country (6.4% in SF vs. 15% nationally [CDC 2013]) and viral load suppression rates that far surpass the national average (64% 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 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 STI¹ clinic) and early adoption of pre-exposure prophylaxis (PrEP) in SF
- The 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: SFPDPH 2015

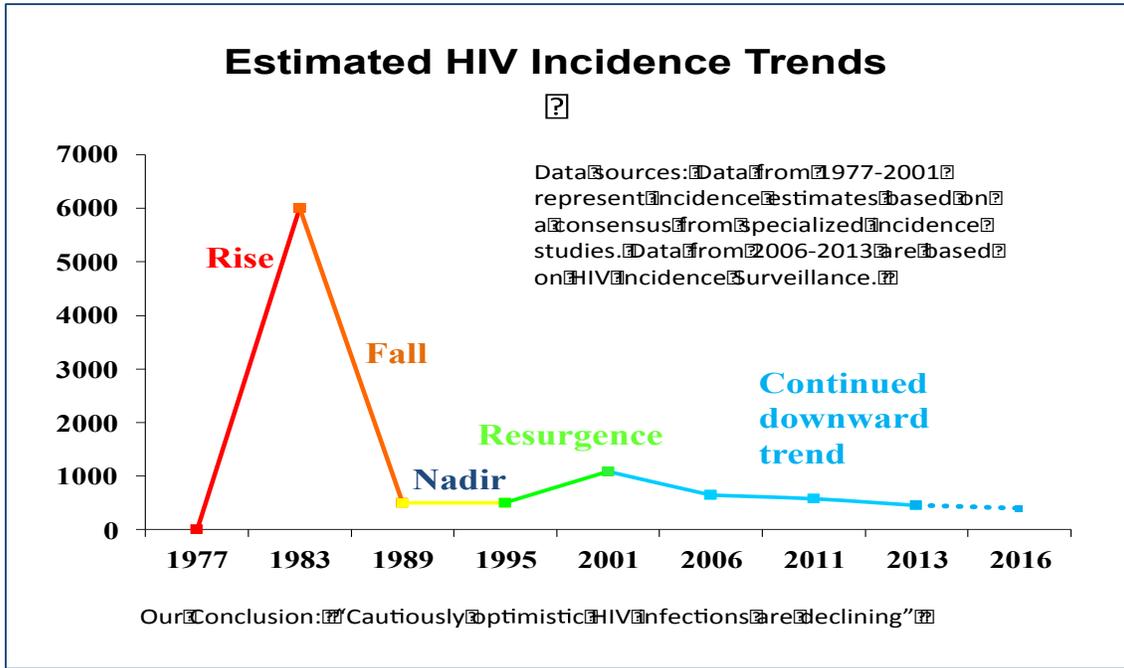
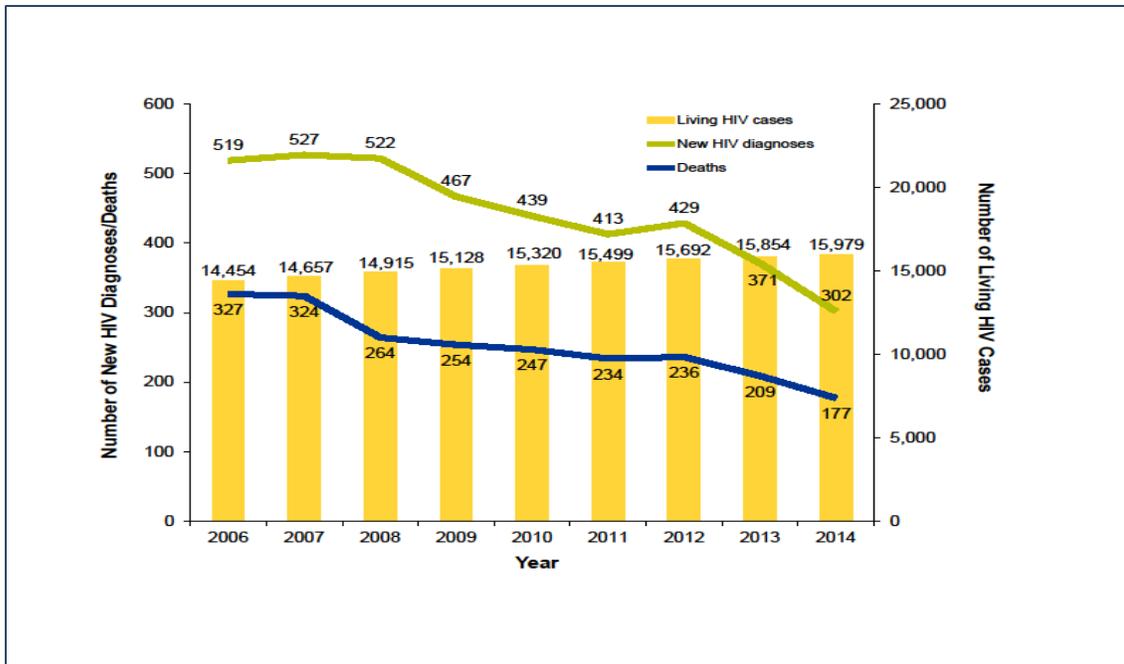


Exhibit 2 New HIV Diagnoses, Deaths, and Prevalence
 City and County of San Francisco

Source:
 SFPDPH



2015

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: SFPDPH 2015

Indicator	Populations with Disparities*
HIV prevalence	<ul style="list-style-type: none"> ▪ Men Who Have Sex with Men (MSM) ▪ Transfemales ▪ African American MSM ▪ African American transfemales ▪ 50 years and older
Estimated Rate of new infections*	<ul style="list-style-type: none"> ▪ MSM ▪ Latinos ▪ Age group 13-29
Less likely to achieve antiretroviral therapy (ART) initiation**	<ul style="list-style-type: none"> ▪ Females ▪ African American ▪ Asian/Pacific Islander (API) ▪ Native American ▪ Multi-racial ▪ Heterosexual ▪ Homeless ▪ Public or No insurance at diagnosis
Less likely to achieve viral suppression***	<ul style="list-style-type: none"> ▪ Female ▪ Transfemale ▪ African Americans ▪ Latino ▪ Current age under 40 ▪ People Who Inject Drugs (PWID) ▪ MSM-PWID

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 94% receiving ART groups with notably lower ART initiation.

***Compared to overall estimate 64% 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 committed to aligning our goals across counties, and in accordance with NHAS. Exhibit 4 shows our progress since the 2014 update. The takeaway message is that the Jurisdiction is making marked progress towards achieving a reduction in new infections and improved health outcomes for PLWH, but must increase efforts and focus on reducing and ultimately eliminating HIV-related 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 2015), 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 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
San Francisco Jurisdiction

Goals	Indicators	Data
Reduce new HIV Infections	<i>New diagnoses</i>	2012: 438 2013: 384 <i>Source: County HIV Surveillance Data</i>
	<i>Estimated % of MSM in SF who are unaware of their HIV-positive status</i>	2005: 23% 2008: 17% 2011: 6% <i>SF only.</i> <i>Source: NBHS</i>
Increase access to care and improve health outcomes for PLWH	<i>Linkage to Care</i>	2011: 86% 2012: 95% 2013: 91% <i>SF and Marin only. Data is linkage to care within 3 months. Marin also collects linkage to care within 6 month (not included here).</i> <i>Source: County HIV Surveillance Data</i>
	<i>Late diagnosis</i>	2011: 24% 2012: 21% 2013: 18% <i>SF only. Data represents the proportion of new HIV diagnoses that developed AIDS within 3 months of diagnosis.</i> <i>Source: County HIV Surveillance Data</i>
	<i>Viral suppression</i>	2011: 59% 2012: 67% 2013: 67% <i>SF only. Data represents the proportion virally suppressed within 12 months of diagnosis. Source: County HIV Surveillance Data</i>
Reduce HIV-related disparities and health inequities	<i>See Exhibit 3</i>	

Measuring Our Progress

In keeping with the fourth NHAS goal related to improving coordination across federal agencies and streamlining data collection, the 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 stakeholder 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

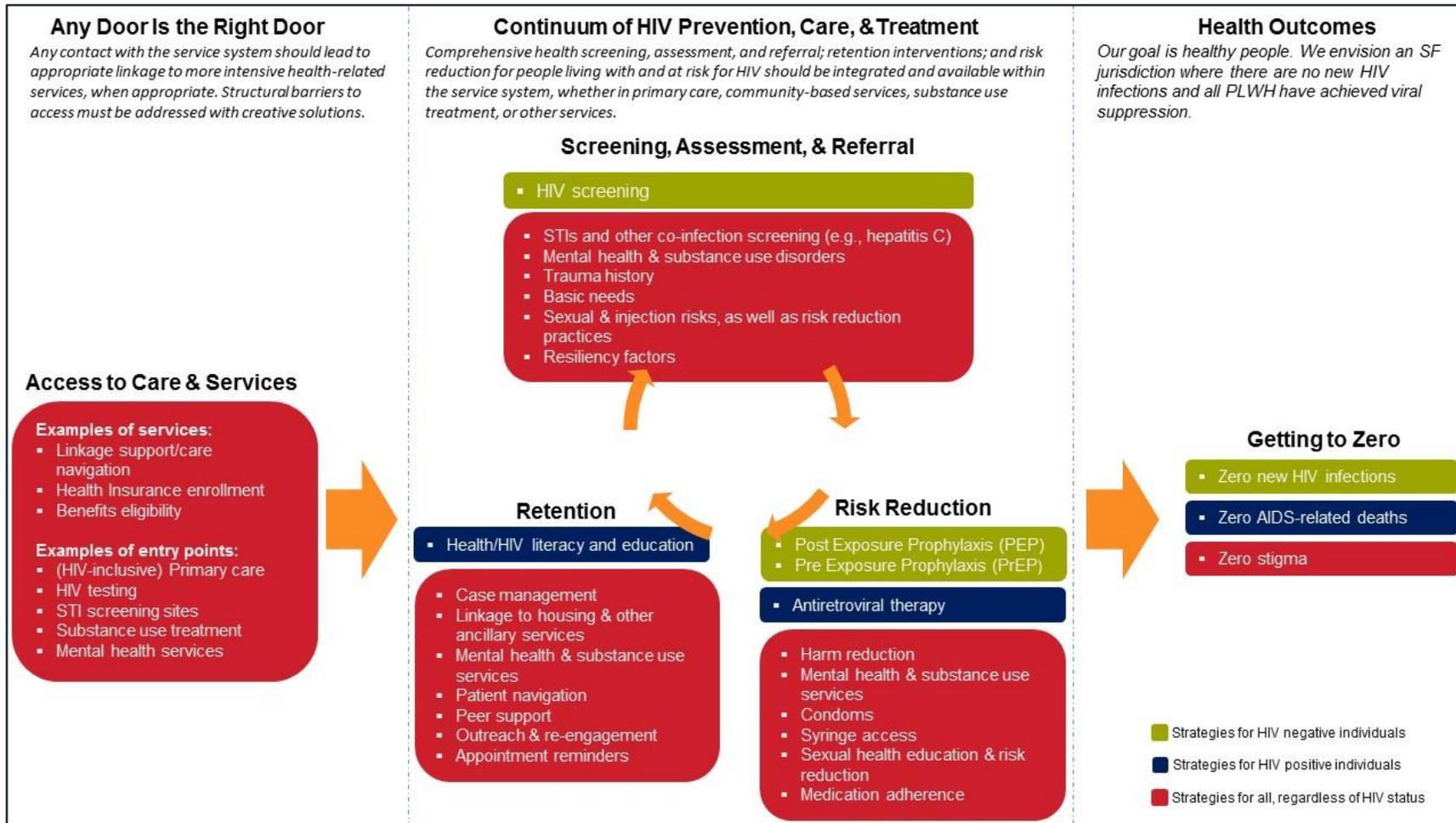
Annual targets will be set for each indicator, and data will be analyzed at least on an annual basis to assess progress. SFDPH will engage multiple stakeholders in this process, including community experts.

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 2015, 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



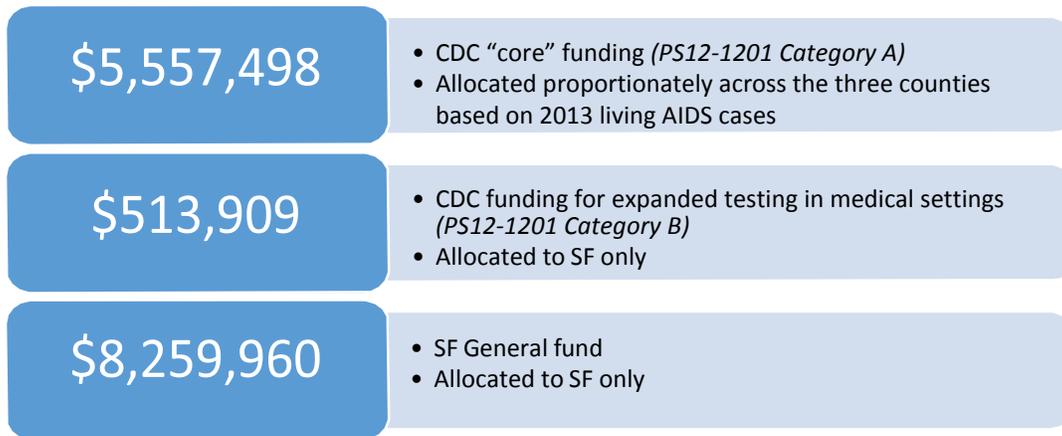
III. RESOURCE ALLOCATION

The SFDPH is the CDC grantee for the three-county jurisdiction. As of 2015, the SFDPH allocates approximately \$14.3 million to support HIV prevention efforts in the jurisdiction (Exhibit 6).

Overview of Resources

Exhibit 6 San Francisco Jurisdictional HIV Prevention Resources

TOTAL = \$14,331,367



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), which was discontinued at the end of 2014
- Non-PS-12-1201 sources of funding used by San Mateo and Marin counties
- CDC direct funding to community-based organizations (CBOs) through PS10-1003 which was discontinued on 6/30/15; PS15-1502 was awarded to one agency as of 7/01/15
- 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

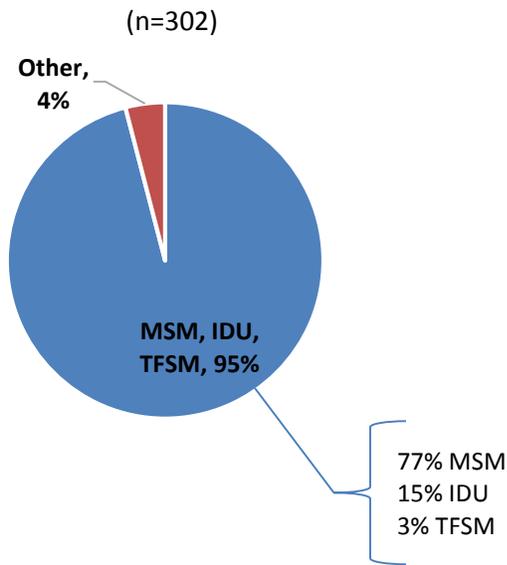
Exhibits 7 and 8 depict resource allocation for 2014. Together, these two exhibits demonstrate that resources are aligned with the local epidemiology. Exhibit 7 shows how resources are aligned across the three counties in proportion to living HIV/AIDS cases. Exhibit 8 illustrates how SF City and County 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
City and County of San Francisco

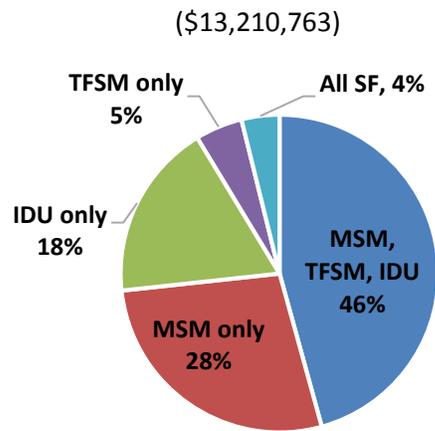
County	Living HIV/AIDS Cases – 2013 (n=17,890)	PS12-1201 Category A Funds Allocated (\$5,557,498)
San Francisco	88.7%	89.6%
San Mateo	8.1%	7.1%
Marin	3.2%	3.4%
TOTAL	100.0%	100.0%

Exhibit 8 Epidemiologic Profile and Resource Allocation
City and County of San Francisco

New HIV Diagnoses, 2014



Resource Allocation, 2015



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.

III. ACCESS TO CARE AND SERVICES

HIV Testing

Since 2012, the Jurisdiction has made great strides in expanding access to HIV testing. San Francisco'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

SAN FRANCISCO

- Determine Combo, the new 4th generation rapid HIV test, is being piloted at two agencies in San Francisco. This acute rapid HIV test reduces the window period for detecting antibodies from 3 months to 1 month. Research has shown that there is a strong correlation between identifying acute cases and new infections. The goal is to link individuals in the acute stage of infections to services rapidly and strengthen partner services.
- 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 SFPDH medical settings using a variety of strategies (e.g., clinician champions, continuous quality improvement).

SAN MATEO

- San Mateo County continues the use of *Grindr* as an internet-based strategy to reach suburban MSM; and, the strategy continues to serve as an effective tool to provide HIV testing information, education, and referrals for this priority population.
- San Mateo County expanded its implementation of *Greater Than AIDS* to include Spanish-language radio spots, targeted placement of billboard ads in disproportionately impacted communities, transit bus ads on major routes, and dissemination of *SMC Greater Than AIDS* posters to businesses, community and faith-based organizations, and to public health clinics throughout the county.
- San Mateo County Health System's electronic medical record now includes alerts for providers to query HIV testing history as a strategy to increase routine HIV testing in primary care settings.

MARIN

- In 2014, Marin began offering Rapid Hep C testing in tandem with HIV testing.
- Marin worked with the Kaiser Family Research foundation to customize the "Speak Out" and "I got Tested" campaigns and provided extensive outdoor placement of ads at bus shelters and mall kiosks in 2014 and 2015.
- Marin is doing promotion of services through social media and public services announcements, including a YouTube video in English and Spanish to help promote HIV testing at Marin AIDS Project <https://www.youtube.com/watch?v=2WgLI29opHY>.
- 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.

JURISDICTION

- 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*

SAN FRANCISCO

- 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 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).

FUTURE EFFORTS - *Implementation*

SAN FRANCISCO

- 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.
- 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.

SAN MATEO

- San Mateo County will expand its Greater Than AIDS campaign in late 2014 to encourage HIV testing.

MARIN

- 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.

Linkage to Care and Partner Services

Rates of initial linkage to care within 6 months of diagnosis have remained high and stable in recent years across the three counties – 83-88% in SF (SFDPH 2015), and 90-100% in Marin (special data request, July 2015). 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

SAN FRANCISCO

- San Francisco has fully operationalized its Linkage Integration Navigation and Comprehensive Services (LINCS) program to provide services to people testing HIV-positive at community and medical test sites. Services include partner services, linkage-to-care for newly diagnosed positives, and navigation with HIV positive people who are out of care. LINCS services are provided by DPH staff, some of whom are embedded at funded sites. Community-based testing site staff has expressed satisfaction with the processes and outcomes of the services LINCS provides. Community norms and acceptability around naming partners is shifting and SFDPH staff members are welcomed. Successful implementation of LINCS is helping San Francisco increase the percentage of newly diagnosed clients who are linked to care and are interviewed for partner services, increase the number of partners testing for HIV, and increase the number of positive people who are engaged in care.
- In 2014, SF and Alameda counties operated under 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. More recently, the Counties are operating under the CA Health and Safety codes 121025-121035 that give protection to designated public health agents to do public health follow up, even across jurisdictions.
- The Positive Health Access to Services and Treatment (PHAST) team has been the HIV Testing and Linkage to Care team for the San Francisco General Hospital (SFGH) campus since 2002. Based at the UCSF HIV/AIDS clinic at SFGH (Ward 86), the scope of service of the PHAST program includes expanded HIV testing on the SFGH campus, rapid linkage to care with immediate HIV Antiretroviral initiation and sustained engagement in primary medical care. The PHAST team provides intensive nursing case management, outreach services, social services, and coordination of care with appropriate community agencies. This program is aimed at 1) expanding HIV testing in all medical and psychiatric settings on the SFGH campus and 2) HIV positive individuals who are either newly diagnosed or already known to be HIV positive who are not adequately linked to primary care services. Special emphasis is given to individuals of minority communities and those who have co-morbid psychiatric and/or substance use conditions. The PHAST team coordinates and collaborates with the DPH LINCS team and other community-based HIV service organizations.

- SF is in the process of developing an integrated data system called PHNIX (Public Health Network Information Exchange). The system is undergoing testing throughout the development process and will be operational in the coming year. The system will maximize public health action by integrating multiple data sources into one platform thereby providing a comprehensive picture of clients service needs. The system will have several unique features:
 - *Integration of HIV testing, linkage and partner services and HIV surveillance data*
 - *Allow Data to Care activities, such as:*
 - ◆ Use routine surveillance to identify individuals who are out of care
 - ◆ Create one record across both HIV and STD programs, as well as TB and other communicable disease programs
 - ◆ Use data to tailor PrEP activities and services to individuals
 - ◆ Use screening data to identify eligible individuals for PrEP and monitor their treatment and adherence over time

SAN MATEO

- San Mateo County continues the use of an HIV Disease Investigator to provide facilitated linkage to care for individuals newly diagnosed with HIV and individuals who have fallen out of care—this includes follow-up with HIV-positive individuals who have incident STI infections.
- San Mateo County’s electronic medical record facilitates linkage to care for HIV positive individuals who have fallen out of care by automatically alerting the HIV Disease Investigator when a patient has not made an appointment in 6 months. Additionally, the HIV Disease Investigator is alerted when a new patient is scheduled for intake, as well as, when a patient has an STI treatment referral but has fallen out of HIV primary care.

MARIN

- Marin is using surveillance data to monitor partner services and identify individuals who are not in care. These individuals are then contacted by case management staff to help remove barriers and link them to services.

FUTURE EFFORTS

SAN FRANCISCO

- 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]).
- 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.

Hepatitis C Virus (HCV)

The hepatitis C virus (HCV) is the most common blood-borne disease, a major cause of liver cancer, and the leading cause of liver transplants in the United States. In San Francisco, preliminary analysis of HCV data indicates that the city's HCV burden mirrors that of the United States in terms of its disproportionate impact amongst people who inject drugs (PWIDs), Blacks/African Americans, and baby boomers (people born during or between 1945 and 1965) (SFDPH 2010). In the United States, HCV prevalence is approximately five times greater than HIV prevalence, and approximately 25% of HIV-positive individuals are co-infected with HCV infection (Edlin 2014). Since 2007, more people die of HCV than HIV each year (Ly 2012).

Community-based antibody screening amongst high-risk populations in San Francisco has yielded an antibody positivity rate of 5.4% (SFDPH CHE&P, 2014), and HCV antibody screening in San Francisco jails has yielded an antibody positivity rate of 10% (SFDPH CHE&P, 2014). Surveillance data also indicates tremendous disparities in HCV prevalence in San Francisco. Black/African American's represent 6.6% of San Francisco's general population, but account for approximately 33% of San Francisco's HCV cases and 23.5% of the population of people who are co-infected with HIV and HCV (SFDPH 2010). Despite the tremendous disease burden of HCV, there has historically been a dearth of federal, state, and local funding for HCV surveillance, prevention, and care activities.

Despite the extremely high disease burden of HCV, there is no ongoing federal or state-specific funding stream available to SFDPH that is dedicated to HCV prevention, testing, linkage to care, or treatment activities. The existing HCV community-based screening and treatment initiatives at SFDPH are the result of the department's creative leveraging of existing resources to address community HCV-related needs.

Preventing HIV transmission is a crucial component in the HCV prevention toolbox – it is known that being co-infected with HIV and HCV increases the likelihood of a person transmitting HCV, and also speeds up the progression of HCV in co-infected people. Co-infection with HIV and HCV can also limit possible HIV treatment options for the co-infected person, and high community uptake of HIV antiretrovirals is a vital component of the "Getting to Zero" strategy.

CORE ACTIVITIES UPDATE

SAN FRANCISCO

- SFDPH conducts core as well as enhanced surveillance. Since 2005, the SFDPH has received funding from the CDC to develop and maintain a population-based registry of persons in San Francisco with past or present HCV infection. Enhanced surveillance activities include interviewing cases and faxing or mailing follow-up surveys to the provider ordered the case's HCV tests. This allows SFDPH to acquire information unavailable through routine public health reporting to better characterize the population of San Franciscans who are infected with HCV. SFDPH also educates persons with HCV infection about how to prevent transmission to their close contacts.
- In the absence of a dedicated funding stream for HCV surveillance, prevention and care, SFDPH has leveraged existing resources to address HCV. SFDPH has integrated HCV screening and counseling

services into HIV prevention programs and offers trainings to community providers around HCV prevention, counseling, and screening administration. SFDPH expanded its community-based screening in 2015 to priority populations including people who inject drugs, people who smoke stimulants, transgender women, and MSM enrolled in the PrEP program at Magnet or City Clinic, the latter in response to the findings that two MSM who were enrolled in PrEP at Kaiser Permanente San Francisco Medical Center’s program acquired HCV. In addition to HCV screening services being offered at SFDPH-funded syringe access programs, four SFDPH-funded methadone programs currently offer HCV screening services to program participants.

FUTURE EFFORTS

SAN FRANCISCO

- Increase HCV awareness among affected populations
- Increase community and clinic-based screening
- Develop a community-based HCV linkage-to-care program. Increase primary care provider capacity to treat HCV within the medical home
- Increase patient uptake of curative therapies

Transgender Health

CORE ACTIVITIES UPDATE

SAN FRANCISCO

- 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). Currently, not all SFDPH sex and gender questionnaires have been revised to capture transfemale and transmale identities. This information will allow for more appropriate delivery of healthcare services for these populations. The process of updating the sex and gender questionnaires is on-going.
- SFDPH’s TransAccess program, which is 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. So far, 50 transgender women of color have been enrolled in the program. Seventy-eight percent (78%) of these receive their medical services on-site with 66% having a viral load of <500. Approximately two out of three identified as homeless at program entry.
- There are a number of programs in San Francisco with a trans-health focus:
 - **The Transgender Clinic at the Tom Waddell Urban Health Center** – Founded in 1993, the clinic offers multidisciplinary primary care for all medical and general health concerns. Mental health and

social services are also available.

- **Castro Mission Health Center Dimensions Clinic** – The clinic offers low-cost health services for queer, transgender and questioning youth ages 12 to 25. Medical and mental health professionals are available to counsel clients and assist them with their medical and mental health concerns. Weekly transgender and gender-variant support groups run by trans counselors are also available.
- **Transgender Health Services (THS)** - Started in August 2013, THS has improved access and quality healthcare for transgender San Franciscans via its Transgender Surgery Access Program for Health San Francisco and Medi-Cal patients. It also partners throughout the SF Health Network to strengthen competency in transgender healthcare at all access points. THS also provides education and preparation programs for patients and caregivers. SFDPH staff train clinics throughout San Francisco on how to work with trans patients and refer them for surgery.
- The Trans Cultural Humility & Training Workgroup, which recently merged with the Trans Coordination and Collaboration Workgroup, is an internal SFDPH working group that has coordinated, facilitated, and implemented all of the transgender 101 trainings as well as the more advanced trans health trainings for SFDPH staff. This workgroup also collaborated with the Sex & Gender guidelines working group in co-authoring, reviewing, and presenting the final document to the Health Commission for approval. Their advocacy and experience was instrumental in the successful approval of these guidelines.
- The Transgender Advisory Group is an external (community-based) advocacy group made up of mostly engaged trans community members. This group is instrumental in connecting the SFDPH with the needs and goings on of the trans communities within our municipal borders.

FUTURE EFFORTS

SAN FRANCISCO

- Expand navigation services in SF to focus on ongoing retention and not just re-linkage to care.
- Develop sex and gender guidelines that adhere to specific data collection principles: 1) Naming should be self-identified; 2) Transgender and sexual orientation data should be coded with caution and care when working with minors in consideration of the fact that health data are legally accessible by guardians; 3) Keep information up-to-date; 4) Naming should allow for both consistency and relevance and compliance and comparability.
- Assess training and technical assistance needs of SFDPH, agencies, and community providers.
- Develop and make available implementation materials to ensure that identity data can be collected appropriately in a variety of SFDPH settings. All new data systems must have the ability to track data in accordance with the sex and gender guidelines.
- Engage in continuous quality improvement by evaluating the sex & gender guidelines through data analysis and stakeholder feedback.

SAN MATEO

- **Transgender Health Services:** San Mateo County has launched plans to pilot a Transgender Health Services Specialty Clinic within the Health System. The pilot project will include comprehensive gender medical and mental health care, as well as ancillary support services. Comprehensive HIV prevention and education services are included as part of the support services available; and, individuals will have access to HIV testing, PrEP, PEP, education and risk reduction counseling, and partner services.

V. CONTINUUM OF CARE

Screening, Assessment, and Linkage

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 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 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, and 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

SAN FRANCISCO

- 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.

FUTURE EFFORTS

SAN FRANCISCO

- 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.
- SFDPH would like to 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.
- 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 will implement the HIV-informed primary care behavioral health model recommendations, referenced above, which include expanding behavioral health screening, assessment, and linkage for PLWARH.

- SFDPH will work with the San Francisco Health Network to prioritize communicable disease screening and develop an approach for implementing integrated screening guidelines.

Risk Reduction

We are fortunate in 2015 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.

In October of 2014, four (4) focus groups were held in San Francisco, each consisting of 5-10 MSM who live, work or play in San Francisco. The focus groups were designed and facilitated by staff from SFDPH and held at Focus Pointe Global. Questions were planned to elicit thoughts and reactions to information about STDs in San Francisco, including HIV, and participants’ ideas about the role of DPH and what they could do better to reduce the spread of STDs among MSM in San Francisco. Following are the ten topic areas and select findings.

Topic	Select Findings
Condom culture among men in San Francisco	<ul style="list-style-type: none"> • Condoms are connected with HIV prevention, not STDs • There is a culture that does not encourage – but often actively discourages – condom use • There is a commitment to regular STD testing in order to quickly diagnose and treat infections • Most participants spoke of pressure to <i>not</i> use condoms
The role of hookup apps in the spread or prevention of STDs	<ul style="list-style-type: none"> • Online apps were named by some as a major contributor to the increase in spread of STDs • Online apps were also seen by some as making it easier to have sex and to communicate • Apps were seen as a way to post information about their HIV status and whether they are on PrEP, so no discussion was needed in person • Many discussed hookup apps as a good opportunity for DPH involvement in STD prevention work
The role of substance use in the spread of STDs	<ul style="list-style-type: none"> • Participants across the groups associated the increased spread of STDs with substance use among MSMs • Several men found substance use to be a necessary part of sexual activity

	<ul style="list-style-type: none"> • There was an acknowledgement that substance use and sexual risk are intricately intertwined and efforts to address this must recognize the relationship between the two.
Concern about STDs	<ul style="list-style-type: none"> • Concern varied depending on sexual activity, relationship status, monogamy, and a low priority compared to other concerns • Men who were concerned about HIV tended to also be concerned about STDs • Men who had experienced an STD, particularly syphilis, expressed increased concern about contracting an STD in the future
Communication with partners	<ul style="list-style-type: none"> • “Assume everyone’s positive” was a common theme • There was reluctance to communicate about status because some felt it was impossible to trust their partners • Others depend on hookup apps to provide information on status • Most participants said that they make a practice of always attempting to communicate to their partners about HIV or STD status with varying degrees of success
Other strategies to prevent STDs	<ul style="list-style-type: none"> • Several men indicated they use condoms, all the time, no matter how much they’d rather not • Partner choice as a main strategy was also common • A group of participants talked about strategic positioning or strategic choices of sexual activity based on risk
PrEP	<ul style="list-style-type: none"> • Six men across four groups were actively on PrEP and thought it was an excellent addition to the HIV prevention toolbox • There was significant concern among some participants about the problems posed by widespread PrEP use • Other conversations on PrEP had to do with logistics, especially cost
Perceived responsibility of the individual	<ul style="list-style-type: none"> • Participants across groups identified places where they thought the individual has personal responsibility to protect himself • Several thought it was very important for individuals to take responsibility for listening to information, making their own smart decisions, and getting tested
Perceived role of DPH	<ul style="list-style-type: none"> • Information sharing was a predominant theme – the importance of continuing advertisements or social marketing campaigns with “real information, not scare tactic information” • Several men described the need for DPH to provide information in the area of resources, rather than prevention how-tos • The other main role for DPH was offering free, accessible testing services • Feedback about Magnet and City Clinic and the quality of services they offered was quite positive

Suggestions related to messaging/social marketing

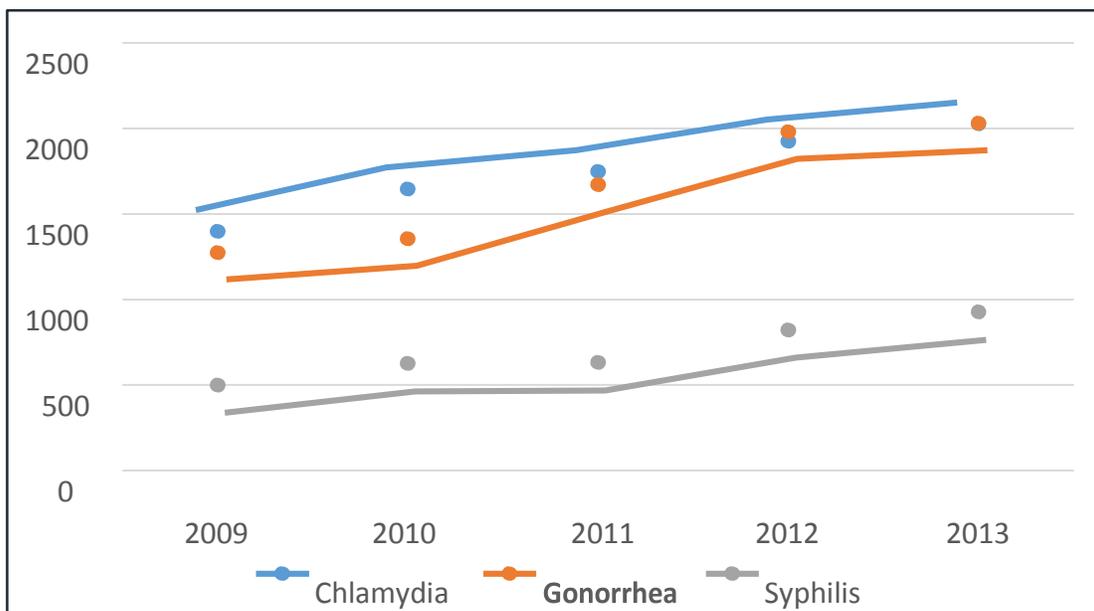
- There was general recall of specific campaigns: the Healthy Penis campaign, “Know Your Status”, Crystal Mess campaign, We>AIDS
- There was general sentiment that infographics were useful and well-received
- Three participants noted that sex still sells in messaging and social marketing
- There was mixed feedback about the use of fear-based messaging in advertising

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, SFPDH, September 2014



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

SAN FRANCISCO

- 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

SAN FRANCISCO

- 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

SAN FRANCISCO

- 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.
- In 2012, the SFDPH implemented the SAMHSA-funded Minority AIDS Initiatives-Targeted Capacity Expansion (MAI-TCE) program. Through the program, patients receive culturally competent and effective behavioral health and prevention services, integrated into their medical care. The results are improved quality of life, reduced impact of behavioral health issues, and improved HIV-related health outcomes, ultimately leading to decreased HIV incidence and reduced health disparities. Several accomplishments in the past year include:
 - ✓ The Behavioral Health/Primary Care Network participated in the development of the MAI-TCE sustainability plan, entitled “*Addressing the Behavioral Health Needs of People Living with and At Risk for HIV in Primary Care Settings.*” The plan provides recommendations for an “**Integrated HIV-informed primary care behavioral health model**” to best meet the behavioral health needs of people living with and at risk for HIV (PLWARH) in San Francisco after the end of the grant.
 - ✓ MAI-TCE was involved with multiple DPH-wide capacity building, training and sustainability efforts including the: Trauma-Informed Systems Training Initiative, Black/African American Health Initiative, HIV Prevention Planning Council’s Behavioral Health and Substance Use workgroups, and Transgender 101 Training Initiative.
 - ✓ In the past year, 91 clients have been enrolled in solution-focused mental health and substance abuse interventions led by a Behavioral Health Specialist (BHS); 16 clients were added to the 30 ongoing clients receiving services at the Transitions Clinic; and 91 clients were enrolled in a binge drinking intervention through the Substance Use Research Unit (SURU) of the SFDPH Center for Public Health Research (CPHR) Branch.
- In October 2014, the HPPC Substance Use Work Group presented recommendations on next steps for addressing HIV-related needs of people who use substances. The workgroup philosophy states: “People who use alcohol and other substances are equal members of the San Francisco community; however, they experience stigma related to their substance use and needless barriers to prevention and treatment.” The workgroup developed the recommendations within 5 priority areas:

Priority Area	Recommendations
1. Harm Reduction	<ul style="list-style-type: none"> Align principles and philosophy of harm reduction across all substance use treatment, HIV prevention and HIV care programs.
2. HIV Prevention, Treatment and Substance Use Programs	<ul style="list-style-type: none"> Ensure that people who use alcohol and other substances have access to treatment and prevention programs that are grounded in the tenets of harm reduction. Recommit to a system of care that offers treatment on demand. Remove the structural barriers imposed by outmoded Civil Service policies that prohibit programs from hiring qualified staff with specialized expertise
3. Interventions	<ul style="list-style-type: none"> Ensure that people who use alcohol and other substances have access to evidenced based interventions for HIV prevention, substance use treatment and HIV care.
4. System of Care	<ul style="list-style-type: none"> Ensure that people who use alcohol and other substances have access to a system of care that is coordinated, cohesive, comprehensive, non-punitive and non-stigmatizing.
5. Criminalization of Persons Who Use Drugs	<ul style="list-style-type: none"> Ensure that people in San Francisco who use alcohol and other substances do not face criminalization as a result of substance use.

FUTURE EFFORTS

SAN FRANCISCO

- 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 San Francisco. 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 buprenorphine 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

- Overdose (OD) is a significant cause of mortality among PLWHARH, and HIV infection puts people who inject drugs at greater risk of fatal overdose. Overdose prevention services can connect people who use drugs to HIV prevention, care, and drug treatment services, and in SF, co-located OD prevention and HIV prevention services help recruit and refer clients to each other. Recognizing the link between HIV and overdose, SFDPH was an early adopter of integrated HIV and overdose prevention programming – the work of SFDPH-funded Harm Reduction Coalition’s DOPE Project has been instrumental in lowering heroin-related overdose deaths in San Francisco from approximately 120 in the year 2000, to fewer than 20 in 2012.

CORE ACTIVITIES UPDATE

SAN FRANCISCO

- The DOPE Project continues to offer individual and group education and counseling alongside prescription for naloxone at syringe access, subsidized housing, and drug treatment programs.
- In 2014 SFDPH partnered with SFPD in an overdose prevention project in which 324 police officers were trained to respond to overdose and received naloxone via the DOPE Project, and the SFDPH-funded DOPE Project also initiated new overdose prevention programming in the county jail. SFDPH also supported an academic detailing program in which prescribing physicians were educated around the importance of co-prescribing naloxone with opiates.
- Naloxone is also available from the pharmacy at 1380 Howard Street for patients receiving methadone and buprenorphine, 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

SAN FRANCISCO

- Support outreach services and consider developing a culturally appropriate social media campaign to reinvestigate harm reduction policies.

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)

Since its introduction in 2012, PrEP has become a powerful HIV prevention tool in San Francisco and is beginning to gain ground in both Marin and San Mateo counties. When taken consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 92% (CDC 2014). Since 2012, when the U.S. Food and Drug Administration approved Truvada as an HIV/AIDS prevention drug, new infections have dropped by 30 percent in San Francisco (ARCHES data – citation needed). PrEP is covered by most insurance plans, as well as Medi-Cal and Healthy SF.

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.

CORE ACTIVITIES UPDATE

SAN FRANCISCO

- In November 2014, San Francisco AIDS Foundation’s sexual health clinic, Magnet, opened its pilot-phase PrEP program. An initial 20 individuals were enrolled in the program. Since the pilot phase ended, Magnet has enrolled 350 individuals into the program. Magnet’s nurse practitioners perform medical evaluations and counsel clients on the health benefits of adding PrEP as part of their sexual health maintenance. To medically clear a client to being PrEP, lab work is done immediately using a state-of-the-art chemistry analyzer that can measure kidney and liver function within 12 minutes. HIV testing is also done to ensure clients are HIV negative. Insurance benefits are then reviewed with the Magnet benefits manager to figure out how they can pay for the medication. Clients then return for a follow-up visit once a month after enrollment. Staff conduct medication adherence checks and provide PrEP counseling. After clients complete their 1-month visit, they return every three months for further evaluation and maintenance.
- Magnet’s Director of Nursing developed a 10-point fact sheet titled “The Basics of PrEP” that provides information on the medication used in PrEP, how to recognize side effects and monitor your health while taking Truvada, and how to integrate PrEP into other personal prevention strategies.

FUTURE EFFORTS

SAN FRANCISCO

- The San Francisco Board of Supervisors has allocated \$301k for PrEP Navigators to be held at CBOs. The funding will be available in the Fall of 2015 and will be allocated through a competitive bid process.
- San Francisco is applying for CDC funding of \$2.9 million to 1) implement high-impact, evidence-based strategies to improve uptake of PrEP among people at substantial risk for HIV in SF, especially MSM of color and TF; and 2) fully implement the CDC Data to Care intervention in SF and increase the proportion of HIV-diagnosed MSM and TF in SF who are virally suppressed, especially for people of color.
- A written training on PrEP for all HIV test counselors is being developed and will be integrated in the HIV test counselor training for new HIV test counselors.
- SFDPH plans to develop and implement an educational framework for medical providers on PrEP using public health detailing or other efforts.
- The SFDPH is considering development of a PrEP clinical policy, using relevant policies as a model such as SF's universal offer of treatment policy or Kaiser's PrEP policy.
- Efforts to increase research financing and insurance coverage of PrEP will also be explored. Additionally, developing pathways for PrEP access will be targeted, with a strategic dissemination plan developed to ensure this information is transferred to communities as quickly as possible.
- Continue to 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.
- 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?
- Magnet is in the process of planning to expand access to PrEP at SFAF's main office at 1035 Market Street. Exact details have not been finalized. They anticipate offering PrEP at 1035 sometime in late August.
- The San Francisco AIDS Foundation, with funding support from the State Office of AIDS and CDC, plans to expand PrEP within primary care services.

SAN MATEO

- San Mateo County assessed clients' awareness, experience with, and interest in PrEP via a questionnaire administered to 100 targeted, priority population individuals encountered on the Mobile HIV Testing van. Only 20% of clients were aware of PrEP, 4% of clients had previously taken PrEP, and 70% of clients were interested in finding out more about PrEP. Additionally, about 51% of clients were covered by MediCal. As a result, SMC has developed PrEP treatment protocols, patient education brochures, and

referral processes for PrEP access through SMC Health System. Additionally, the SMC website has been updated with PrEP information for both providers about and patients.

MARIN

- Marin is exploring providing PrEP at the HHS Clinics - STD services.

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 sero-adaptation. 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

SAN FRANCISCO

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.

FUTURE EFFORTS

SAN FRANCISCO

- 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 3,359,526 syringes, an increase from previous years.

CORE ACTIVITIES UPDATE

SAN FRANCISCO

- 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 d improperly discarded syringes found in these areas.
- In summer 2014, the Community Health Equity branch of DPH, in collaboration with the San Francisco AIDS Foundation, and community placed 2 additional boxes in the Tenderloin as part of a pilot disposal plan.
- At the end of 2014, a request for an outdoor disposal box came from the Director of HOPE and local businesses because of an increase in discarded syringes and a growing homeless encampment in the area under the freeway (15th/Alameda). A thorough community process was done to inform the community of the pilot proposal. The community supported the plan, and a box was placed in December.
- In early 2015, additional boxes were approved by the community to be placed in the Tenderloin.
 - √ Currently there are 4 small disposal boxes and one large kiosk in the Tenderloin.
 - √ A total of 7 small disposal boxes in San Francisco and one large Kiosk at Glide.
- The **Pit Stop** is a project operated by San Francisco Public Works that provides portable toilets and sinks, used needle receptacles and dog waste stations in San Francisco's most impacted neighborhoods. The Pit Stop facilities are staffed and trucked to and from the sites daily. The solar-powered toilets are serviced daily at a remote location before returned to the Pit Stop locations. San Francisco Public Works is operating the Pit Stops in partnership with the nonprofit SF Clean City, which staffs the locations to keep the facilities safe and secure.
- Though not directly funded by the SFDPH, **Lava Mae** is an organization that provides mobile showers for the homeless. Their mission is “to deliver dignity and unlock the opportunity for those experiencing homelessness – one mobile shower at a time.” They recently requested SFDPH to provide syringe disposal boxes in the restrooms of their mobile facilities.

JURISDICTION

- 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.
- Beginning January 2015, licensed pharmacists have the discretion to sell hypodermic needles and syringes to adults age 18 and older without a prescription to reduce the spread of HIV, hepatitis C and other blood-borne diseases. There is no longer any limit on the number of needles and syringes that an adult may purchase and possess. These changes to California law were made by Assembly Bill 1743 (Ting, Chapter 331, Statutes of 2014).

FUTURE EFFORTS

SAN FRANCISCO

- 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.
 - ✓ Provide syringe disposal supplies (tongs, bio-bins, and fit-packs to Homeless Outreach Team (HOT)) so they can educate about disposal at encampments.
 - ✓ Provide bio-bins & tongs to SFPD Tenderloin Station so that all patrol cars have ability for safe disposal
 - ✓ Continue to review 311 data reports on discarded syringes to keep abreast of hot spots
 - ✓ Collaborate with SFPD to formalize system to provide quarterly roll-call trainings at stations in Hot-spot areas
 - ✓ Develop & implement training plan at SFPD Academy for cadets and seasoned officers.

Retention

Marin County has very high HIV care retention rates because county staff members 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

SAN FRANCISCO

- 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).
- 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.
- Currently the HIV Health Outreach Mobile Engagement (HHOME) Project has 49 clients enrolled, 29 who are actively receiving care and 17 clients who have transitioned into either a primary care medical home, or the most appropriate level of care. Client transition plans include Ryan White Part A-funded Center of Excellence programs (one of which is a partnership between Asian Pacific Islander Wellness Center (APIWC) and TWUHC), long term nursing facilities, respite, hospice and, in some cases for the most acute clients, palliative care. Sixty percent (60%) of current clients enrolled in the HHOME team are on ART.

SAN MATEO

- 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.

MARIN

- In Marin County, case managers and outreach staff provide ongoing retention support to patients (appointment reminders, etc.) resulting in high retention rates.

FUTURE EFFORTS

SAN FRANCISCO

- 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.

VI. 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 2015 and beyond.

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. Stigma is difficult to combat and requires recognition of its reach and impact, as well as strategies that are multi-faceted and complex. While *Getting to Zero* is an important goal for the Jurisdiction, there is the very real danger that groups unable to reach that goal will be further stigmatized.

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.

Racism, Homophobia, and Transphobia

SFDPH's Trauma-informed Systems Initiative will provide training to all 7,000+ SFDPH staff. A trauma-informed approach considers multiple factors on a program, organizational and system level (SAMHSA 2014):

- Realizes the widespread impact of trauma and understands potential paths for recovery
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices
- Resists re-traumatization actively of clients and 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).

SFDPH launched its Back/African American Health Initiative (BAAHI) in April 2014 to address the health disparities seen in San Francisco's Black/African American population.

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.

In March 2015, the Mayor’s Office of Housing Opportunity, Partnerships, & Engagement (HOPE) and the San Francisco Interfaith Council launched a pilot program at a temporary location at 1950 Mission Street. The Navigation Center is complex of buildings with dormitory-style living quarters, shower and bathroom facilities, laundry facilities, counseling offices and a 24-hour dining room.

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

In 2012-2014, the Jurisdiction has engaged in various efforts to address the impact of the Affordable Care Act (ACA) on HIV prevention, including development and implementation of the SF Health Care Reform Task Force (HCRTF) (<http://www.sfhiv.org/community-planning/hiv-healthcare-reform-task-force/>) and working to increase SFDPH capacity for billing of HIV testing. Through these and other processes, specific issues and barriers to maximizing ACA have been identified. Attempting to address these barriers will be the priority for 2015 and beyond.

Examples of barriers include:

- Interruptions of continuity of care upon release from jail/prison if HIV/HCV infected (individuals are required to re-enroll or un-suspend Medi-Cal and get linked to a primary care medical home).
- Substance abuse treatment settings (e.g., methadone clinics) are unable to order or bill for communicable disease testing under managed care, unless patient signs a release allowing the facility to communicate with the patient's primary care provider.
- There is no clear mechanism for billing peer-based services, such as patient navigators, community health workers, etc.
- There is no clear mechanism for billing longer-term mental health support for HIV+ and at risk individuals to address complex needs related to risk reduction, medication adherence, substance use, etc.
- There is a lack of information from CDC regarding future funding for community-based testing.
- A number of structural barriers within DPH regarding billing for services delivered by the Population Health Division (as opposed to the SF Health Network).
- There are limitations on coverage for STI counseling – USPSTF defined counseling as 30+ minutes long with a doctor.
- Current lack of coordination locally between DPH and CBOs on billing-related infrastructure and overall policy.

Despite these barriers, there has been one significant success of the ACA that has had an impact locally. Medi-Cal coverage has expanded to cover expensive yet curative treatment for HCV, allowing gains to be made in ending the HCV epidemic that may have taken years to accomplish otherwise.

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, especially given recent challenges to SF's sanctuary city policy). 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-evaluating eligibility 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 current integration efforts for SFDPH are as follows:

- Implementation of integrated HIV prevention and care community planning (see below).
- Cross-division initiatives within SFDPH, in which PHD and SFHN collaborate to ensure population and patient health (e.g., health eating/active living, tobacco, HCV, PrEP).
- Scale-up and integration of hepatitis C testing into HIV and other services.
- HIV prevention providers developing a model for tobacco education and referral that can be integrated into HIV prevention services.
- Provision of Mental Health services integrated into the primary care setting for people living with and at risk for HIV.
- Drug user health initiative that integrates and aligns funding, services, and policies that affect drug users in San Francisco.

The CDC and HRSA emphasis on integration is a policy initiative that will shape our response to the many on-going challenges inherent in the shifting health care environment. Joint efforts that erase the lines between care and prevention and integrate services on a continuum is now the future of HIV services.

Housing

In February 2014, the Mayor's Office of Housing and Community Development (MOHCD), the Department of Public Health (DPH), and the Human Services Agency (HAS) launched a strategic planning process to create a revised HIV/AIDS housing plan for the City and County of San Francisco. The plan noted several important trends that have important implications for addressing the housing needs of individuals living with HIV and AIDS in San Francisco. They include:

- ✓ Housing in San Francisco has become increasingly expensive, exceeding the values established by HUD's Fair Market Rents (FMR) and making it difficult for subsidy programs to be implemented effectively.
- ✓ There are significant numbers of individuals who are aging while living with HIV/AIDS.
- ✓ Many of those who are newly diagnosed with HIV are homeless.
- ✓ Persons with HIV/AIDS are living longer and have more stable health due to antiretroviral therapy.

The Stakeholder Planning Council, which convened in May 2014, developed a set of goals and strategies regarding the use of both financial and human/organizational resources:

- **Goal 1:** Maintain current supply of housing/facilities dedicated to supporting PLWHA
- **Goal 2:** Increase supply of housing/facilities dedicated to supporting PLWHA
- **Goal 3:** Increase resources available for subsidizing/making & keeping housing more affordable for PLWHA
- **Goal 4:** Expanded access to services for PLWHA that help increase housing stability
- **Goal 5:** Improved efficiency and quality of housing and service delivery system

Currently, funding streams for San Francisco's HIV housing include three major sources and are administered by a number of city and county agencies:

1. Housing Opportunities for People with AIDS (HOPWA)
2. Ryan White CARE Act (RWCA)
3. General Fund (GF)

Examining the time trends of financial support available for HIV/AIDS housing services suggests a discouraging outlook, according to the extensive 5 year housing plan. Little has changed since 2007 in RWCA and GF support. Due to the continuing rise in housing costs across the area and the level funding seen over nearly ten years, fewer and fewer resources are available to address the significant housing crisis among PLWHA in San Francisco.

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 community groups were engaged to inform the development of this 2015 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 14
- HPPC Jurisdictional Plan Work Group (invitation to HHSPC to participate?)
- Key informant Interviews with SFDPH Population Health Division Staff
- HIV Health Services Staff
- Transgender Advisory Group meeting on June 22
- HIV Testing Coordinators meeting on July 10
- Latino Providers Network on July 22
- HPPC/HHSPC Joint Leadership Workgroup July 23
- HPPC Executive Committee July 23
- Draft sent to Hepatitis C Taskforce for comments on July 27
- Draft sent to Syringe Access Collaborative on July 29
- Draft Sent to HIV/AIDS Providers Network for comments on August 3
- 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.

Collaborative Planning Efforts

In the winter of 2014, the San Francisco HIV Health Services Planning Council (HHSPC) and the San Francisco HIV Prevention Planning Council (HPPC) implemented the Transition Work Group. The Transition work group met three times with the goal of developing clear objectives & steps for the Joint Leadership work group. The Transition work group developed three motions to establish the make-up and structure of the meetings for the Joint Leadership Work Group. The Joint Leadership Work Group is currently working with a consultant to develop an implementation plan.

The mission of the Joint Leadership Work Group is to prepare for and define the scope of work of the merged councils. The Joint Leadership Work Group is scheduled to meet from May through December of 2015 and will operate as a joint work group between HHSPC and the HPPC. The purpose of the merge of the Prevention and CARE Planning Councils is to ensure a continuum of HIV services for community members at risk for and living with HIV. The Joint Leadership Work Group will convene for an all-day retreat on July 31, to begin mapping their work for the remainder of the year. The Councils will have a joint Council meeting in October to further strengthen their efforts.

Next Steps

The release of the joint CDC and HRSA planning guidance in June 2015 provides a blueprint for the development of an integrated HIV Prevention and CARE Plan to address local issues of access to and effectiveness of prevention, care and treatment for all communities within the jurisdiction. Efforts to coordinate the development of the integrated Ryan White HIV/AIDS Program Parts A and B Comprehensive Plans and the CDC Jurisdictional HIV Prevention due in September 2016 are being coordinated by the leadership of both Prevention and CARE Councils.

In preparation for the development of an integrated HIV Prevention and Care Plan, a number of priorities should be considered:

- A substantial percentage of people continue to be diagnosed late in the course of their infection
- Although linkage to care has steadily increased over the past several years, there continues to be a substantial number of people not linked to care
- Racial disparities continue to persist in some areas, however in some areas, such as case rates, the disparities are less pronounced. This warrants further examination in order to minimize disparities, particularly among Black/African Americans
- Further work in promoting PrEP awareness and knowledge is needed in order to increase access for transfemales and PWIDs
- Data on HIV and PWIDs needs to be increased in light of recent evidence that HIV testing rates among this population are decreasing while the rate of undiagnosed HIV infections appears to be increasing
- According to recent findings in the NHBS for MSM in 2014, PrEP use is up, however condom use is down. Data also suggest that STD rates are increasing within this population. The percent of MSM with 3-5 condom-less sex partners is also on the rise. Preliminary data point to broad community trends related to condom use and number of partners that may not be directly influenced by PrEP use. For example, viral load suppression may be one factor that is driving choices around condom use and partner selection. It is unclear what the broader significance of these trends are and more information and discussion on these findings are needed as we continue to expand and refine our prevention strategies
- NHBS data also indicate that PrEP use is largely confined to white, educated, upper income MSM and MSM, who prior to PrEP, were HIV-negative serosorting as their primary prevention strategy. Efforts to expand PrEP awareness and uptake among MSM of color, and also among MSM who are not negative/negative serosorting and are having sex with HIV-positive/unknown serostatus partners

VIII. CONCLUSION

This update to the Jurisdictional Plan illustrates the success of HIV prevention efforts in San Francisco, San Mateo, and Marin counties. The strategies presented in this plan reinforce our commitment to eliminating HIV-related health disparities within the Jurisdiction. This update represents the strength of our commitment to a holistic approach to caring for the individual. Our programs will continue to expand their mission and scope to include overall health. 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