Ending the Epidemics

COLLECTIVE STRATEGIES FOR ADDRESSING
HIV, HEPATITIS C, AND SEXUALLY TRANSMITTED INFECTIONS
IN SAN FRANCISCO

Developed by a broad coalition of city government and community-based stakeholders in San Francisco, through funding from CDC's PS-19-1906 and with the support of Facente Consulting

Table of Contents

◹ Introduction

In Fall 2017, the San Francisco Department of Public Health (SFDPH) launched a planning process for the future of HIV, hepatitis C (HCV), and sexually transmitted infection (STI)[1] programs and services, to develop a coordinated and integrated strategy for addressing these epidemics, given the overlap in the populations experiencing disparities in each. This "HIV/HCV/STD Roadmap" effort was inspired by a number of driving forces, including continued health disparities in some San Franciscans, changing needs among affected populations, level or decreasing funding, and the continued existence of disease-specific programming and funding streams. SFDPH sought to develop a Roadmap that would take a more whole-person approach to HIV, HCV, and STI prevention, care, and treatment. The Roadmap supports the implementation of services that will help SF reach the following goals:

> **1** Get to and stay at zero new HIV infections, zero HIV-related deaths, and zero stigma
>
> **2** Eliminate HCV
>
> **3** Reverse the increasing STI rates and prevent congenital syphilis

San Francisco has made extensive progress in recent years and is seen as a national and international leader in HIV, HCV, and STIs. Citywide successes have included:

- Adopting of HIV treatment as prevention, including through same-day treatment starts
- Exemplary pre-exposure prophylaxis (PrEP) efforts
- A signature Centers of Excellence model (a one-stop integrated HIV care clinic network)
- Robust HIV linkage and retention efforts
- Citywide strategies to increase HCV treatment and cure
- A sex-positive approach to service delivery
- The only 5 day/week sexual health clinic in the country (City Clinic) with integrated family planning, HIV care, PrEP, and state-of-the-art STI diagnostics and treatment
- Strong partnerships among SFDPH, the HIV Community Planning Council (HCPC), Getting to Zero (GTZ), the HIV/AIDS Providers Network (HAPN), and End Hep C SF

Nevertheless, over the last 5-8 years the landscape of HIV, HCV, and STIs has changed considerably in San Francisco, even before the COVID-19 pandemic hit. Epidemiologic profiles have shifted, and HIV, HCV, and STI efforts are at a crossroads. The impacts of social determinants of health, such as lack of housing and income inequality, are more pervasive and intense than ever before. An ever-expanding national racial justice movement is elevating the dialogue around systemic racism and its role in the health inequities seen, especially among Blacks/African Americans. Resident tolerance for continually growing and increasingly visible homelessness and drug use is unusually low, given San Francisco's history as a progressive and compassionate city. All of these factors strongly suggest the need for an increased focus on person-centered, integrated services and increased innovation to keep up with changing times.

Yet while this plan was under development, the SARS-CoV-2 virus reared its head, leading to a global pandemic of COVID-19 that not only affected our planning process but reshaped our ability to provide HIV, HCV, and STI prevention and care services in SF—perhaps permanently. We knew before COVID-19 that consequential shifts would be required in the city's policies and approaches

---

[1] This plan uses the term STI, except when referring to a document or source where the term STD is used.

to these diseases, for us to realize the goals of getting to zero, ending HCV, and turning the curve on STIs. Now, it is clearer than ever that our systems will require an overhaul to help us get back on our feet. What HIV, HCV, and STI efforts will look like alongside a continuing COVID-19 epidemic is uncertain, to say the least. As such we have reframed our vision of this plan to be a living document, and it is sure to change dramatically in the next couple years as our recognition of COVID-19's impacts continues to grow. We know that many of our core strategies for addressing these epidemics continue to be relevant and effective, and other strategies may be gone from our toolbox forever. Of great concern are the ways that COVID-19 is starkly exposing the cracks in our systems and programs for vulnerable populations—especially for communities of color—and the ways it is further exacerbating racial health disparities. For now, we are committed to continuing to work together, listening to what the community needs, and striving to innovate and plan for ending these epidemics in our city the best we can, upholding our values within a changing landscape.

Section I: Community Engagement

San Francisco has several existing mechanisms for community engagement, all of which came together to develop a "Roadmap" for how SF could improve health related to HIV, HCV, and STIs. The Roadmap process consisted of 19 meetings, using a method called "scenario planning,"[2] to which all the community engagement partners were invited. The process resulted in a set of recommendations that were adopted by the HIV Community Planning Council in 2019 to guide future work.

Existing Community Engagement Mechanisms

Both as a result of and preceding Roadmap recommendations, San Francisco has had a robust set of mechanisms for engaging deeply with community members and providers to inform strategies related to HIV, HCV, and STI prevention and care. **Exhibit 1** on the following page details the many key partners in this work, including End Hep C SF, the Drug User Health Initiative, Getting to Zero, the HIV Community Planning Council, the Black/African American Health Initiative (BAAHI), and various community efforts to gather input related to STI prevention. Members of these partner entities range widely, from high-level staff within SFDPH to decision-makers in community-based organizations to physicians and other providers, to community members with life experience invaluable to discussions about how to create or modify programs or structures moving forward.

More details about each of these community engagement mechanisms are provided in the subsequent pages following **Exhibit 1**. This meaningful involvement from community voices has been a substantial part of San Francisco's development of HIV, HCV, and STI community planning prior to 2019, when the CDC-funded PS-19-1906 funding began; in fact, our first step in developing this plan was to gather and synthesize the mountain of information gathered through these processes over the past many years, to be sure to honor the time spent suggesting disruptive innovations to date, and not unnecessarily rehashing old conversations yet again.

Once information had been integrated from community voices heard through these existing mechanisms, we were poised to build upon that prior work and deepen our understanding of how to make meaningful changes in a shifting landscape, which was much of the focus of our planning work under PS-19-1906.

---

[2] Enzmann, Dieter R et al. "Scenario planning." *Journal of the American College of Radiology*. 2011, 8(3): 175-9.

Exhibit 1: San Francisco's ongoing community engagement mechanisms.
More detailed descriptions of each mechanism begin on the next page.

	DRUG USER HEALTH INITIATIVE
Syringe Access and Disposal	**Members:** SFAF, Glide, SFDUU, SJI, HYA, DOPE Project **Community Engagement Activities:** • Discuss challenges or successes on the streets • Best practices • Incorporate the needs of people who use drugs into programming as needs change Syringe Access Collaborative partners help recruit community members for focus groups such as Meth Task Force, help with convening panels for community meetings, and provide guidance on current trends.
Community Health Response Team	**Leadership:** Community Health Equity & Promotion branch of SFDPH **Community Engagement Activities:** • Active outreach with people experiencing homelessness • Picks up and disposes syringes • Distributes naloxone and other safer drug use supplies Feedback is gathered from community members during active street outreach, or by inviting them to focus groups or other community meetings during outreach shifts.
DOPE Project	**Community Engagement Activities:** • Continuous informal check-ins with community members to get feedback about what is going on with drug supply, etc. • Formative research with community members to develop social marketing campaigns • Work with community members to get drug samples, test at the lab for contaminants, publish the results and make them available to the community • Solicit community feedback about fentanyl, and publish updates and advice about use of fentanyl testing strips
Harm Reduction Training Institute	**Community Engagement Activities:** • 1-on-1 informal conversations with community members to gather input on current and future activities • Group conversations and more formal focus groups when appropriate Non-staff members are usually paid for their time when providing insights to the organization.
	GETTING TO ZERO
Adolescent and Young Adult	**Community Engagement Activities:** • Focuses on the HIV-related needs of adolescents and young adults (AYA) in SF • Uses surveys, focus groups, and assessments to engage AYA in assessing their needs • Does active outreach and recruitment to ensure there is AYA representation on the committee
RAPID	**Goal:** 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 smoothly transition to their medical home. **Community Engagement Activities:** • Uses surveys, focus groups, and assessments to engage the community in assessing their needs • Conducts active outreach and recruitment to ensure diverse committee representation
Ending Stigma	**Goal:** Eliminate prejudice and discrimination against people living with HIV and communities disproportionately impacted by the disease. **Community Engagement Activities:** • Uses surveys, focus groups, and assessments to engage the community in assessing needs • Active outreach and recruitment to ensure diverse committee representation

Retention and Engagement	**Community Engagement Activities (recent examples):** • Conducted a survey of over 100 HIV professionals working in SF to learn the types of barriers faced in accessing behavioral health services • Conducted a survey with PLWH who identify as homeless or marginally housed to explore ways to help them stay on medication by collecting data on barriers to adherence
PrEP	**Goal:** Improving knowledge and access to PrEP in the community, increased provider capacity, and tracking PrEP uptake and impact. **Community Engagement Activities:** • User hotline for information and resources • Speakers bureau of PrEP users • Frequent surveys, focus groups, and assessments to understand community needs.
HIV COMMUNITY PLANNING COUNCIL (HCPC)	
Community Engagement	**Members:** SFDPH, CBO, and non-aligned community members **Community Engagement Activities:** Educate the Council on specific underserved communities and high-risk populations and ongoing and emerging issues for people living with HIV and at highest risk for HIV.
PLWH Advocacy Group	**Members:** PLWH. Most are consumers not aligned with SFDPH-funded services. **Community Engagement Activities:** Regular input to HCPC about the needs of PLWH.
Full Council Meetings	**Members:** Volunteers and government appointees, including PLWH, community members, and representatives of agencies providing HIV-related services and programs. **Community Engagement Activities:** Collaborative regional planning.
Community Listening Activities (CoLAs)	**Coordination:** HCPC staff, Community Engagement Committee **Community Engagement Activities:** • Performs large needs assessments periodically • CoLAs: mini group needs assessments for identified client priority populations (e.g., women)
STI PREVENTION	
SLAY	**SLAY (Sistas Leadership for African American Youth) Intervention for Young Women** **Community Engagement Activities:** • 16-week program to provide recommendations on reaching B/AA youth • Pilot informed by community research • Recruitment through community effort and community leader recommendation • Moving forward, SLAY will include young women and young men.
MSM Partners Group	**Community Engagement Activities:** Regular community advisory group to provide routine feedback on activities, services, social marketing materials, etc. through various community engagement events, focus groups, online/email forums, and meetings.
Focus Groups	**Community Engagement Activities:** Focus groups with members of the general public to discuss access to sexual health care in SF; this feedback was incorporated into the new STD Prevention and Control Strategic Framework.
Key Informant Interviews	**Community Engagement Activities:** Fifteen key informant interviews with internal and external stakeholders to gather information on collaboration, services and care for STIs, perspectives on rising STI rates and health disparities, and gaps in the SF system for STI prevention and care.
Large Group Forum	**Community Engagement Activities:** A large group forum held in June 2019 with 36 members of San Francisco Department of Public Health and the broader community to discuss the mission, vision, guiding principles and strategies for sexual health.

	BLACK/AFRICAN AMERICAN HEALTH INITIATIVE
Sexual Health	**Community Engagement Activities:** A workgroup sponsoring a two-day Reproductive Justice Summit in 2020 called Black Women Know, designed to combat racism, specifically anti-black racism, and create an anti-racist culture in reproductive health care services for all people in SF with true health equity. **Principles:** It will be guided by the life course model, acknowledging racism as a root cause, and centering the expertise of Black/African American women in SF. **Participants:** People who receive reproductive and sexual health care services in SF, students at all levels, and health care professionals who work for a community serving organizations, agencies, or any other institution.
Heart Health	**Community Engagement Activities:** A workgroup, also known as the Hypertension Equity workgroup that: • Utilizes patient advocates from primary health care clinics to inform the work of the work group • Supports food pharmacies at several primary care clinics

	END HEP C SF
Community Meetings	**Community Engagement Activities:** Community meetings in a community space, held twice per year, for anyone interested in learning more about hepatitis C (HCV) and providing insights into new strategies for HCV elimination. These events are widely promoted and planned to be accessible, encouraging a thoughtful exchange of ideas.
Research and Surveillance	**Community Engagement Activities:** Monthly open workgroup to determine important research questions related to HCV elimination, and support efforts to answer those questions.
Prevention, Testing, and Linkage	**Community Engagement Activities:** Monthly open workgroup to guide work around HCV prevention, testing, and linkage services.
Treatment Access	**Community Engagement Activities:** Every other month open workgroup to guide work related to expanding and improving access to curative HCV treatment for all people with chronic infection.
Executive Advisory Committee	**Community Engagement Activities:** Intended for physicians, administrators, and other leaders who are not able to regularly attend End Hep C SF workgroup meetings; this committee meets twice a year to provide input on the future work of the initiative.

New Voices

SFDPH has an excellent track record of convening key stakeholders, and there is always something new to learn by directly engaging with community members who might not be part of existing advisory boards or work groups. Community members who are already involved in ongoing engagement efforts are likely not representative of the people that HIV/HCV/STI efforts have the most challenges reaching. Recognizing that the voices of community members not involved in current efforts are not well-represented, these people became the focus for bringing new voices to the table. To that end, San Francisco released a Request for Proposals (RFP) in February 2020, for consultant services to establish meaningful and ongoing community engagement pathways with five overlapping San Francisco communities that are most impacted by HIV, HCV, and STIs:

- Blacks/African Americans
- Latinx
- Trans women
- People who use drugs, including people who inject drugs
- People experiencing homelessness

Four organizations with deep connections to at least one of these communities were funded, and each designed and facilitated a community advisory process eliciting community feedback to ideas in an earlier draft of this plan, as well as newly proposed disruptive innovations to end HIV, HCV, and STIs in their community. As these organizations were just getting their proposed community engagement activities off the ground, COVID-19-related shelter-in-place orders in San Francisco went into effect, requiring a rapid revamp to using creative virtual engagement methods. More details about each of the community engagement activities undertaken to hear from new voices in these communities are provided below, with documentation of each meeting in **Appendix 1**.

Black/African Americans (B/AA): In May 2020, AIDS Project East Bay convened nine focus groups of 10 B/AA community members who were described as leaders by members of their personal social networks. These participants had diverse sexual and gender identities, and a variety of perspectives and lived experiences. The participants completed a self-administered written questionnaire, then participated in facilitated focus group discussions guided by the questionnaire, held over Zoom. AIDS Project East Bay staff led the recorded sessions and compiled participant comments.

Latinx: In preparation for in-person community engagement sessions, the Cause Data Collective created a participant engagement tool in English and Spanish, using an earlier draft of this plan. Between late spring and September of 2020, Cause Data Collective hosted 25 virtual Zoom-based sessions with a total of 40 Latinx participants, using small groups or individual interviews. A Core Group of 5 advisors with a history of community leadership regarding HIV, HCV, and STIs for Latinx people in San Francisco also met on 10 different occasions to plan for small-group sessions or interviews, and analyze data coming in to help comprehensively inform the EtE plan.

Trans women: San Francisco Community Health Center (SFCHC) solicited input and feedback from trans women through a series of 34 individual key informant interviews and 5 focus groups during spring and summer of 2020. The 60 community members who participated were a diverse sample of clients from SFCHC's trans programming, with first-hand knowledge of and lived experience with SF's system of care and prevention, housing options, and other issues and challenges facing this community. Most focus groups were conducted over Zoom, and most individual interviews were conducted in-person at SFCHC's health center; all activities were in compliance with federal, state, and local social distancing guidelines and safety protocols.

People who use drugs (PWUD): The San Francisco Drug User's Union (SFDUU) solicited input and feedback from both PWUD and people experiencing homelessness, two populations with considerable overlap. Four informal events including lunch and discussion were conducted at SFDUU between April 24 and August 24. A total of 75 attendees who were residents of two San Francisco homeless encampments, participants of SFDUU, or friends and acquaintances of SFDUU staff who are PWUD participated in the discussions. All attendees were current PWUD or on medication-assisted treatment (MAT); approximately half were unhoused at the time. Forty-seven participants identified as male and 27 as female.

People experiencing homelessness: SFCHC solicited input and feedback from people experiencing homelessness and housing instability. Prior to the current pandemic environment, people without stable housing in San Francisco were a highly transient population, with little access to technology and often living with multiple diagnoses including mental illness, substance use, and chronic illness. The recent shelter-in-place order has required the City to provide permanent locations where unhoused people can shelter in place and isolate, which has reduced overall transience, but has posed new challenges such as social distancing requirements and limitations on in-person gatherings and support groups –venues where data collection with people

experiencing homelessness and housing instability is most feasible. For these reasons, SFCHC developed a lighter-touch, lower-threshold means of collecting important information from the community, using a nine-question data collection tool and staff trained in culturally competent and trauma-informed interviewing methods. In June and September 2020, 178 people experiencing homelessness were surveyed in the Tenderloin neighborhood. Most of the surveys were self-administered, with a few transcribed by the team. Interviews conducted in June lasted approximately 30-60 minutes; acting on participant input, for the September interviews participants were given the option to participate in a shorter 15-minute street-based interview. The team was vigilant about wearing masks, maintaining social distance, and sanitizing all shared equipment and tools.

Key Findings from Engagement of New Voices

Despite the experiential differences of people who participated in community engagement activities across these five groups, many of their comments shared similar themes. Among these were the need to see themselves represented among providers, a need for safety and security, a need for greatly expanded access to services, a need to be able to simplify access to the multiple forms of support needed, and a need to combat healthcare stigma. We share these overarching findings here, as—along with the epidemiological profile and situational analysis featured next—these voices set the stage for the development of the disruptive innovations featured here in the core of this plan.

Need for representation: Across the board, participants wanted to see themselves represented at all levels of medical and service providers. A lack of representation in providers, clients, and healthcare systems reinforced B/AA participants' thoughts that they were "underserved, undervalued, and over-exploited" by the healthcare system. Providers should not only "look like" their clients, but have similar experiences. As one participant said:

> *"There are no Black doctors, and not enough Black folks teaching harm reduction. It's best/easier to hear the info and get education from folks like us."*

Participants cited representation as a pivotal factor affecting how a medical clinic is viewed. They noted that it is important, however, that this be genuine representation and not tokenism; in fact, having Black and brown people only in lower paid, less powerful positions—as outreach workers, navigators, medical assistants, and health aides—only emphasizes the systemic racism inherent in the system. There was a common feeling that lack of access to basic and professional education for communities of color and other marginalized communities, inadequate employment training programs, and systemic racism, classism, and discrimination prevent the "right people from doing the work."

> *"I would personally like to see the EtE support the enhancement of the Black public health workforce…This should include science and treatment knowledge, social justice, racial equality, emotional intelligence, anti-stigma language, trauma informed care and other public health outcomes intersectionality."*

Trans women, too, seek representation in their service providers. Participants noted that it was crucial to work with someone who shared their lived experience, and "inspirational" to be served with someone who experienced the same struggles and has made it to a better place. But they also note that it's not sufficient to simply hire trans women for these positions; retention is also key. Staff turnover can "set back the clock" when it comes to building trusting relationships with the trans community. But again, community representation has to be genuine. One participant shared:

> *"I would like to see community representation, but sometimes it feels forced. I was reached out to and they were like 'we want a trans black person on the committee' but they haven't talked about trans or black specific issues."*

This need for representation also applies to boards of directors and others making decisions. The need for people with lived experience throughout the system was reiterated over and over:

> *"A whole lot of people like me don't have PhDs or Masters degrees. But we have ideology… growing up in the street and being homeless and sleeping in the street and not having food to eat."*

Peer programs can be especially useful for clients. One group of PWUD took it further, and imagined a "buddy system," where both the client and the buddy would be compensated a portion up front, and a portion on completing the doctor's visit. Almost every participant in this group said they would follow through with a doctor's office visit if they had a friend accompany them.

> *"When I have someone with me, I can do things so much easier."*

However, the volunteer nature of peer-to-peer programs or low incentives paid to community members for their knowledge and insight are insufficient compensation, and communities would be better served by fostering skills-building, job readiness, and professional skills. Genuine training opportunities for community members that provide a leg-up into the professional world and are a gateway to jobs with a living wage and benefits will improve how priority populations are served. People providing these crucial services must receive appropriate institutional support to do their jobs, and they need to be respected. One Latinx participant explained the "poverty mentality" of the institutions he worked for when he asked for more support. He was told "we don't have enough money, we don't have enough personnel, consider yourself lucky to have a job…having a job should be reward enough."

Indeed, many of the experiences that make peers and staff relatable to clients may impact their ability to comply with traditional work setting expectations such as dress code, attendance, etc. Intentional and equitable organizational support for peers helps to support, build, and foster the community that encourages staff retention. As one participant noted, "it would be good to have mentorship and have people show [peers/people experiencing homelessness] how to be." They also noted that it is crucial to ensure that people with lived experience also have access to affordable mental health care: "people who have experienced [homelessness], it doesn't make them saviors and they may need someone who's thinking about them." A Latinx focus group suggested creating a team of diversity liaisons who would be a bridge between Latinx employees and the bureaucratic culture. These liaisons would be

> *"Bilingual and bicultural. They're not only responsible for work getting done, but responsible for wellness of people doing that work."*

Outreach: Community Engagement participants were looking for messaging that "spoke" to them, and that was hopeful. Participants noted that people living marginally have enough fear; they need hope. These sessions demonstrated that outreach and marketing is definitely not one-size-fits-all. While there were some examples of strong, helpful campaigns focused on their communities, participants also spoke of experiences of being added into ads as a token, of multilingual campaigns that were simply translations of those for other groups, or of not being marketed to at

> "Do more outreach to Black communities. We don't know about PrEP/PEP."
>
> Community Engagement Participant

all. As one participant put it: "Actually advertise to the homeless!" Outreach around PrEP is a good example of this—in engagement sessions for each community, participants spoke of how many people still assume that "PrEP is only for gay people." Members of B/AA focus groups said that the larger Black community didn't know much about PrEP, and what they did know was limited and contributed to stigma; i.e. PrEP shaming, the promotion of "raw"/condomless sex, promiscuity and other negative sexual behavior connotations. Similarly, people experiencing homelessness and housing instability were also largely unaware that PrEP would be beneficial to them, especially trans and cisgender women and men who participate in survival sex.

When developing marketing materials for a specific community, it is also key to keep that community's norms in mind. For example, while current best practice of sex-positive messaging resonates with many, that messaging may not work for more conservative Latinx communities who respond better to a more extended family- or community-oriented message. Similarly, many Latinx community members come from cultures that don't discuss mental health—yet they have experienced trauma due to war, poverty, and physical and sexual abuse. They need outreach that can direct them to treatment they may not even be aware of, and that is culturally, linguistically, and experientially competent. This treatment needs to extend beyond crisis and high-risk care, to ensure that they'll receive treatment even when they are not in a state of crisis.

"El trauma es una fuerte herida que uno lleva en el alma. No se puede ver pero ahí esta...El día que uno se da cuenta que estas abierto a amar o lo que sea, sabes que has superado parte de ese trauma. Esta manera sencilla de verlo es importante para los jóvenes que nunca realmente han sido expuestos a la psicología."

"Trauma is like a wound in your soul. You can't see it, but it's there…the day you can say you're open to love or whatever, you know, that means that you have overcome a little bit of your trauma. This simple way of seeing it is important for young people who have never really been exposed to psychology."

In addition, the "messenger matters"—respondents want the people delivering the messages to represent the community or communities they're trying to reach. Some participants thought that ads and other messaging were sometimes difficult to understand and would be better received if they were presented in a more fun way. Some Latinx participants recommended using recognizable and charismatic people—"celebrities in the community, like drag queens"—to deliver outreach messages. Others remarked that in some Latinx cultures, people have a very hierarchical relationship with their doctors and would be more likely to take advice from doctors than from average people in campaigns.

Especially within the Latinx engagement groups, there was an interest in providing outreach to church and religious leaders, to reduce stigma. It was noted that many faith-based communities do a great job providing food and services but that they hadn't noticed a similar faith-based coalition in San Francisco specifically directed toward the Latinx community.

A final concern was about communication methods. Many of the participants experiencing homelessness noted the need for alternative ways to stay connected that are not reliant on particular devices that can be lost, stolen, broken, or lack power. These participants also recommend having ads that people can show to friends who don't have phones. Latinx participants were concerned about outreach methodologies, noting that traditional outreach methods based on venues and neighborhoods wouldn't be as successful in today's San Francisco, but should instead be placed in places where people walk or wait, such as bus lines or BART, or through social media.

"My concern with outreach…[is that] doing outreach in SF nowadays…is somewhat outdated. We don't really have venues."

Need for safety and security: The issue of safety—of people as well as information—was foremost in many people's minds. Members of these priority populations have and continue to experience ongoing, complex trauma.

"Not having enough food is trauma-inducing. Not having a secure and safe place to live is trauma-inducing. Working in conditions that may lead you to contract a disease that could not only disable and kill you but also your loved ones is trauma-inducing…Not being able to access essential services because of a hostile police force and federal government, including ICE, is trauma-inducing."

People may have emigrated from war zones, or have experienced deep, recurring stigma or violence, and they often have a high degree of distrust in medical institutions. Providers who have been marginalized themselves—having had direct experience with homelessness, substance use, mental illness, institutional racism, etc.—are better able to build trust and rapport in communities where there is typically and historically a high degree of distrust. Providers need to understand trauma-informed care and the complexities of clients' psychosocial experiences so that they can build trust, empower, and help clients feel safe. In addition, they need to create a safe, respectful, welcoming, warm, and non-judgmental environment when providing care to highly traumatized populations, many of whom may have had to overcome fear in order to seek healthcare at all:

"I was mistreated by the staff at the hospital and called sir. I didn't feel like the doctor or nurse listened to me. I felt embarrassed by the way they treated me, so I didn't go back. It was very disrespectful."

Participants noted that continuity of care is critical, because if hard-won trust is established and then a provider disappears, this increases overall distrust and disappointment in the system. It is traumatic for clients to have to build new relationships and retell their story over and over again. Getting all one's needs met in one place creates a feeling of safety, belonging, and community, which makes it easier to consider accessing new types of services. Clients need to know that they will receive care without being stigmatized for being homeless, using drugs, for being transgender, or for engaging in sex work. They also need to be accurately reassured that accessing the healthcare they need will not jeopardize their life in the United States.

It is critical that services spell out that client information is confidential and will not fall into the wrong hands. While participants were strongly in favor of representation in the clinics they attend, there was also concern about hiring staff from tightly-knit communities. In a community where everyone knows everyone, confidentiality can be a concern, and if a client doesn't feel safe sharing personal information for fear that it may get back to their family and friends, they may not get appropriate care.

B/AA participants were especially concerned about a potential lack of confidentiality in surveillance and partner notification practices, and their comments highlighted the need to build trust within the community. Participants felt these types of case investigations are "stigmatizing" and "exactly why Black people don't want to get tested now". There was a concern that these types of programs would support existing medical

> "It's hard enough being Black, people already treat us different because of the color of our skin, we can't hide or change that but damn now we can't even protect our health status?"
>
> Community Engagement Participant

mistrust and conspiracy theories, and might have negative effects on employment, housing, personal safety, family/community relationships, and other aspects of one's individual mental health. The overall group consensus was that contact tracing and investigation would "deter most Black people from ever getting tested." Community members in these engagement sessions remembered historical events such as the Tuskegee syphilis study, in which B/AA persons were deliberately denied curative treatment for their syphilis by the government and healthcare system, and therefore maintain a high level of medical mistrust. They referred to attempts to convince them of data security efforts as embracing a "white agenda". Earning trust among this community will be instrumental in the success of efforts to end the epidemics, particularly in Pillar 4 (Respond).

Confidentiality is a key concern for immigrant populations, as well, because of the fear community members have of the police and government. Immigrants may fear that using services will jeopardize their ability to remain in the country, or simply draw hostile attention:

> *"I remember when I first started going to the City Clinic, I was a little concerned. I asked my attorney if it would be okay to take the treatment for HIV from a public agency because they are giving me medication for free. I was concerned that it could affect my asylum process. I always have those concerns."*

Community building: In order to end the epidemic, it is critical that health care providers help generate self-worth for clients, particularly those who have experienced a lifetime of abuse and systemic oppression the way these priority populations have. Low self-worth creates a core belief that noting will get better no matter how hard one tries, so trying is a waste of effort.

> "A man told me the other day that all I am is a sex object and not a human, but I cried because I am so much more. I love god, my family, animals, and my life."
>
> Community Engagement Participant

So how does one overcome the damage to one's self-worth caused by a lifetime of abuse? One suggestion by participants was community support, facilitated by actual community members. Engagement in daily routines that involve both caring for others and being cared for by others builds a sense of community. Having a sense of community was especially important for trans participants and people experiencing homelessness. Involvement in a trusted community provides a sense of belonging and worth that makes it possible to access and utilize tools and services. A community can help its members understand that they deserve to protect themselves and their communities:

> *"Having community makes me feel like I am worth protecting…I value when others in my community show genuine concern for my well-being and want to help protect me."*

Participants emphasized that incorporating community and holistic programs "[don't] need to get people housed automatically…They need to be treated by helping them figure out who they are besides HIV+ and having hep C."

Care that is available and accessible: Participants frequently commented that while care might be available, care that was only accessible at limited times or in remote locations might as well not be available at all. Clients may work long hours or multiple jobs, live a more nocturnal lifestyle, or live in neighborhoods that have long been underserved. Ensuring that services, especially same-day treatment services, are available at a time and place that works for them is key to ensuring that they will use those services. It also means clients can access services without having to take time off

and lose money they need to survive, and reduces the shame associated with being late or missing an appointment window. Some clients suggested that the mobile van be stationed in areas where the community lives and works, or assigned to places where people already need to go, such as the laundromat or grocery store. Others commented that typical 9-5 hours and long wait times made it impossible for them to go, and that sites should be open until 8 pm, 11 pm, or even later:

> "You know, a lot of [Latinx people] work in restaurants, and they can't get tested…we have to make it accessible where they can go at a time where is it good for them, you know, because…some of them work 9 to 5 or some of them work 11:00 at night and get tested because things are closer, you know."
>
> Community Engagement Participant

> *"Meeting them where they're at. A lot of the disconnect [is] with the services and screenings. If I'm a sex worker, I'm not going to access services at certain times. When the agencies are open, I'm still asleep. When I'm up, things are wrapping up. Starting at 4 or 5 pm. Let the employees come in later and stay later, then you'll capture more of the community."*

For PWUD, this inaccessibility can manifest in having to go from clinic to clinic at 6:45 in the morning, hoping to find a site that will take them on as a new methadone patient. For people who are unhoused, it can mean having to decide whether to seek medical care, or to deal with the necessities of life. One participant put it very succinctly:

> *"We use our energy on food, a place to poop, and safe place to sleep. Medical care isn't a priority."*

In the B/AA focus group, no participants knew of any places offering health services specifically tailored for homeless individuals. They said most healthcare agencies treated unhoused people as "second class," and discriminated against them for things like hygiene, mental illness and other non-controllable factors.

People experiencing homelessness expressed a need for services in the many neighborhoods where they live, including the Bayview, the Castro, and Golden Gate Park. They were especially interested in testing, treatment, and prevention services provided by street medicine teams and mobile PrEP vans. They noted that services that are brought directly to them makes them feel "prioritized", and helps ensure that services are readily available to them. Finally, participants had a strong preference for being referred to "specific people, not institutions." When not given a name of someone to check in with, the process of entering a new place for care or support can feel overwhelming or confusing, and it can be easier to procrastinate or skip altogether, because there's no accountability to anyone. Participants also expressed a desire for "easy restart"—that is, being able to obtain treatment again after a gap without shame or filling out complicated paperwork all over again.

Bureaucracy is often overwhelming, especially for people who are immigrants, who must navigate a complex combination of barriers. Many don't have insurance support, whether because of a fear of having to provide documentation that they might not have, a lack of information, or concerns about cost:

"(O principal problema) Seria realmente o acesso a informação, existe um medo de ser muito caro e eu achon que o que me engajaria seria realmente o acesso a informação Porque conheço amigos que tem (seguro de saúde), mas cada um conta uma história diferente, então eu nunca sei o que esperar. Eu acho que se eu tivesse mais acesso a informação (das informações pessoais necessárias) [...] se eu soubesse essas informações exatas com mais certeza, com certeza eu já teria feito".

"The main reason I don't engage with the healthcare system is that] it would really be access to information, there is a fear of being too expensive and I think that what would get me to engage would be having access to information. Because I know friends who have [health insurance], but each one tells a different story, so I never know what to expect. I think that if I had more access to information [about what information I needed to get healthcare], [...] if I knew this exact information with more certainty, I would certainly have done it already"

Simplified care access: Many participants said that services were difficult or time consuming to access and that most of them weren't under one roof. Participants said that having agencies with wrap-around services and more opportunities would help support enhancing access and engagement outcomes. This "one-stop shop" model of care was extremely popular among participants in the community engagement conversations. The idea of being able to access medical, mental health, substance use, housing, food, legal, and other services in a single location at a single time saves clients time and effort. If an individual is struggling with substance use or mental illness, in addition to homelessness or housing instability, this drastically impacts their ability to engage in medical care. If they are able to come to one location to address all of their needs, there is a much higher chance of engagement and retention in whole person care.

"Why not come here and receive testing for HIV, STDs, hep C, life skills, hormone therapy, mental health therapist, substance abuse counseling … if that's what you desire to have? Get you something to eat, a car lift, just make it as easy as possible for you to be more involved in bettering you and bettering your healthcare. Have that experience more common for you. Not enabl[ing] you but the next time you have that experience you want to go there."

These might be full-service sites, such as service fairs, one or more mobile vans, kiosks at encampments, or resource hubs in high risk areas that provide pamphlets and a resource guide. Participants recommend that SFDPH collaborate with community stores in key neighborhoods such as Bayview or Sunnydale to locate kiosks in the areas in which they would be most useful. Many participants suggested ideas similar to those put forward as part of the pending SFDPH OPT-IN[3] prototype service models soon to be piloted: 1) On-call mobile clinicians, who deploy to street locations when notified by an outreach team; 2) a trio of mobile vans, which deploy weekly to known, scheduled sites; and 3) pop-up clinical spaces located in non-clinical venues, such as laundromats, meal programs, drop-in centers or other social spaces, or SROs, which would put multiple providers at a single site. One community engagement participant suggested:

"Expand one stop (integrated) testing to reach people who may not visit regular medical/clinic sites. The idea of the 'food truck' concept but extrapolated to health diagnosing and resources, including warm handoffs to treatment sites and follow up."

---

[3] OPT-IN is an acronym for Outreach, Prevention, and Treatment Integration; a program of the San Francisco Department of Public Health designed to improve HIV and hepatitis C prevention and care for people who are unhoused, marginally housed, and/or otherwise severely underserved by our current systems of care.

Another factor affecting access to care is transportation. Increased transportation options and affordability, as well as alternative care routes for people who are living with disabilities and/or facing discrimination, improve safety and ultimately access to care. People who are trans or gender non-binary and people experiencing homelessness frequently have experiences that are stigmatizing or dangerous on public transportation, and expressed a desire that additional modes of transportation be offered. In addition, the COVID-19 pandemic has demonstrated that limiting the number of times clients must travel and interact with providers is imperative. Enabling clients to meet as many needs as possible in a single visit is not only a matter of convenience, it is potentially a matter of safety.

A final concern was related to how COVID-19 was changing the provision of healthcare. Community members express a need for financial assistance as well as better information:

> *"Places are closed now, so it's hard to get places so people would need to be out there more. What if there was a number that you could call for Truvada? Let's say it's 2 AM, why isn't there a number that I can call or a way that I can just get it like at a hospital or something? It's easier to solve a problem when you have the emergency room, or people or a team that you can just easily find and have a conversation with."*

The rise in remote service provision, participants noted, was a challenge for priority populations such as African Americans, people experiencing homelessness, the unstably housed, and other marginalized communities where many people have limited access to technology. As one participant put it:

> *"The "new normal" is for people that have jobs and money. They can afford to adapt and conform for a new normal. Our friends and families can't."*

One suggestion for a way to address this was a small phone/computer center where clients could receive results and medical information quickly with minimal wait times and paperwork. Ideally, this space would be a small drop-in center where social distancing could be easily followed, with computers and free landline phones available. Participants were especially interested in having the ability to check email, do research, and check medical records; most importantly, having Zoom installed on the computers would allow people to attend virtual therapy sessions or doctor's appointments. Having phones available at these locations would also be a critical communication resource for people who lose their phones or have them stolen.

Stigma: Another recurring theme among participants was their experience of stigma. Stigma was a topic in every community engagement session, and in some cases was cited by participants as the largest barrier to accessing healthcare. Participants experience stigma from both providers and other community members, related to HIV, race, gender, sexuality, immigration status, drug use, and homelessness. These stigmatizing actions take different forms: trans women described having to articulate that they are not "men who have sex with men" when being questioned around HIV risk; people experiencing homelessness feel unwelcome in healthcare facilities due to lack of access to spaces where they can clean themselves; PWUD describe having their complaints of pain ignored by providers. Particularly within communities of color, anti-gay stigma was felt to be a barrier to testing or treatment. One heterosexually-identified MSM participant said:

> *"Getting tested isn't the hard part, it's everything that comes after. You have to worry about people finding out, hiding your meds, what your family will think, plus everyone will think you're gay."*

It was broadly felt that, in addition to improved representation, provider education would help to combat stigma. Participants suggested that providers need more understanding around cultural norms, trans health, gender affirmation, sexual identity/orientation, sexual health and behaviors, pop culture, chemsex, harm reduction, and other intersections between provider knowledge, attitudes and beliefs.

Participants noted that in order to recapture the trust of people who have experienced mistreatment or stigma in healthcare, healthcare organizations must acknowledge responsibility for past harms and work to end current mistreatment such as racism, transphobia, marginalization, and disparities in care. For trans people, this requires providing gender-affirming care that includes provision of health care services such as hormone therapy, as well as using of correct terminology and pronouns, providing facilities that are trans inclusive, and having health-related materials that are relevant to trans individuals. This was made clear by one trans participant, who said:

Participants also advocated for the normalization of HIV/HCV/STI testing as part of regular health treatment; as one participant put it, "Health screenings, not HIV testing". According to our community engagement conversations, providing a broader and more generalized suite of services, including such things as diabetes screening, COVID-19 testing, and others, will bring more people into the umbrella of testing and reduce the associated stigma.

Section II: Epidemiologic Profile

Background

Located on the shores of the San Francisco Bay, the City and County of San Francisco is home to an estimated 881,549 residents[4] in 47 square miles, the smallest county by area in California. Connected by bridge to Marin County to the north and Alameda County to the east, and contiguous with San Mateo County to the south, San Francisco has often been described as a city of neighborhoods **(Exhibit 2)**. This is especially true today, with growing income and health outcome disparities often defined by neighborhood boundaries. Neighborhoods such as Bayview/Hunter's Point, the Mission, Haight Ashbury, and the Tenderloin (described below as Civic Center/Downtown) have higher rates of residents who are people of color, unhoused or at risk of becoming unhoused, and living with HIV, HCV, and/or STIs.

Exhibit 2: Map of neighborhoods in the City and County of San Francisco.[5]
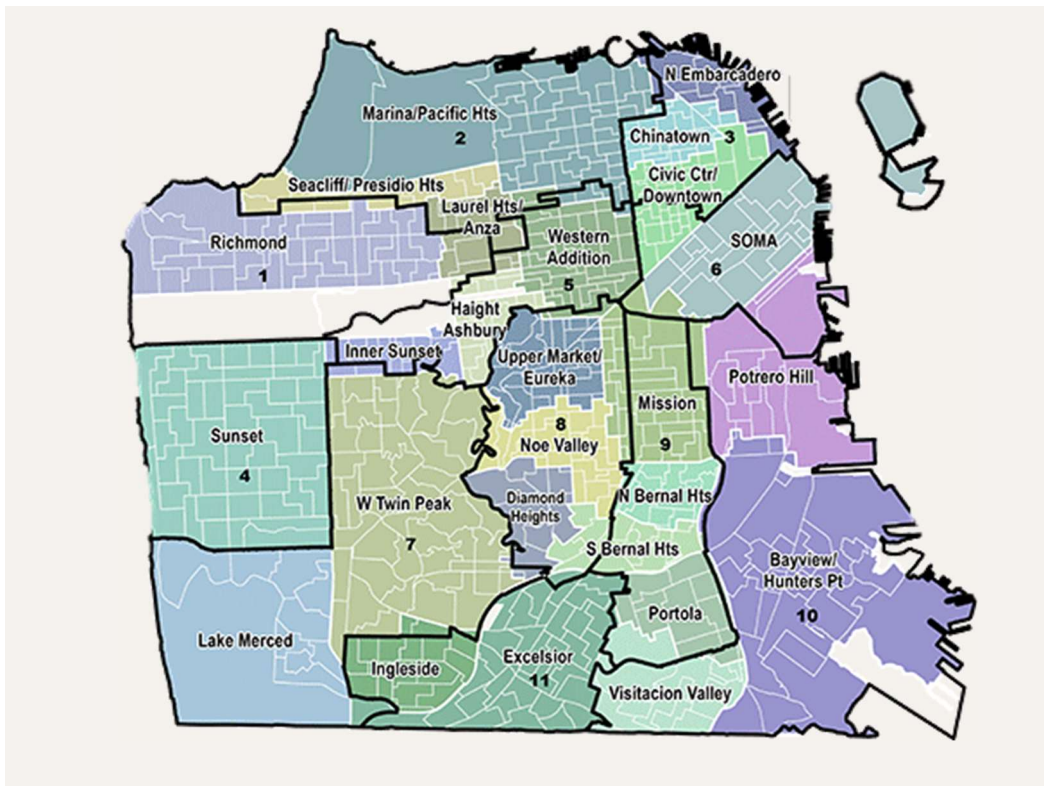
Given the overlap in the populations experiencing disparities in HIV, HCV, and STI prevention, SFDPH has developed a coordinated and integrated strategy to address these epidemics. While each epidemic is addressed separately in this Section, the overall plan will address all three epidemics jointly where appropriate, to ensure a more whole-person approach to HIV, HCV, and STI prevention, care, and treatment.

---

[4] US Census Population Estimates for San Francisco County, 2019.
https://www.census.gov/quickfacts/fact/table/sanfranciscocitycalifornia,US/PST045219
[5] Bernal Hype newsletter, available here: https://bernalhype.com/2020/02/12/letter-to-the-community-from-district-9-supervisor-hillary-ronen/

PART 1: HIV [5]

HIV

1 NEW DIAGNOSES HALVED BETWEEN 2013-2018

399 (2013) 197 (2018)

New HIV diagnoses decreased by >50% from 2013 to 2018. There were 399 new cases diagnosed in 2013 and only 197 in 2018.

2 PROPORTION OF DIAGNOSES SHIFTING

2009: BLACK / LATINX / WHITE
2018: BLACK / LATINX / WHITE

71% of new HIV diagnoses were among people of color in 2018, an increase from only 52% in 2009.

3 VIRAL SUPPRESSION LOWER AMONG BLACK/AFRICAN AMERICANS

SUPPRESSION — BLACK / WHITE
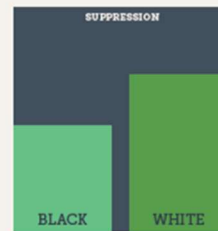
Only 68% of Black/African Americans were virally suppressed in 2018, compared to 76% of Whites.

4 VIRAL SUPPRESSION LOWER AMONG UNHOUSED
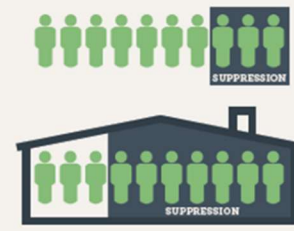
33% of people living with HIV who were also experiencing homelessness were virally suppressed compared to 75% of housed people, in 2017.

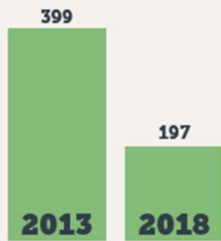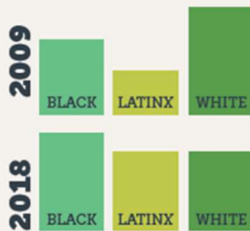*NOTE: while racial/ethnic groups are described broadly here, it is important to note that there are significant differences within them that affect these statistics. Future data collection should be done more granularly to incorporate this nuance.*

Successes and Observed Improvements in HIV Prevention and Care

In 2018 new HIV diagnoses declined to a historic low of 197, the first time ever that new diagnoses fell below 200 (**Exhibit 3**). This represents a 13% decrease from the previous year and a decline of 63% since 2006.[7] Also of note, no children (age <13) have been diagnosed with HIV since 2005, representing the success of perinatal programs providing preconception counseling and pre- and post-natal care to women living with HIV. Survival with HIV continues to improve; 89% of people with stage 3 HIV (AIDS) diagnosed from 2012-2016 survived for three years compared to only 23% of persons diagnosed with stage 3 HIV between 1980-1989. Additionally, the majority of deaths now occur among persons 50 years and older. Deaths due to HIV-related causes declined to only 38% of all deaths in SF between 2014-2017 as

Exhibit 3. HIV Diagnoses in SF, 2006-2018.[6]

New HIV diagnoses reached a historic low in 2018

compared to 52% of all deaths from 2006-2009.[8] As a result, San Francisco has an aging population of PLWH: currently, 67% of PLWH in San Francisco are 50 years or older and 30% are 60 or older.
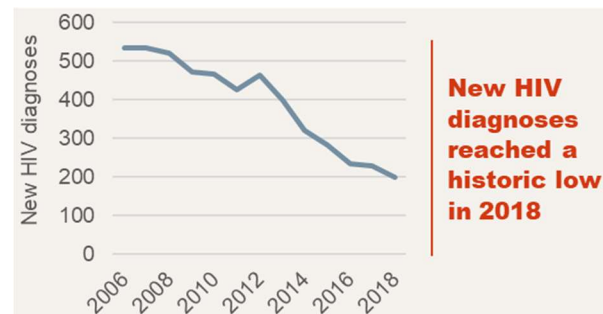
Knowledge of one's HIV-positive status is necessary for engagement in care, and is high in San Francisco. Overall, 94% of PLWH are aware of their HIV status. High awareness, along with increased efforts and services in San Francisco to help PLWH get into and stay in medical care and to start treatment as soon as possible after diagnosis have helped improve HIV-related care and treatment outcomes.

---

[6] Ending the Epidemics Steering Committee. Current State of the HIV, HCV, and STI Epidemics in San Francisco, 2019.

[7] San Francisco Department of Public Health. (2019). *HIV Epidemiology Annual Report, 2018*. Retrieved from San Francisco, CA: https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/HIV-Epidemiology-Annual-Report-2018.pdf

[8] Ibid

Among newly diagnosed persons in 2018, 91% were linked to care within one month of diagnosis and 78% were virally suppressed within one year of diagnosis.[9] In addition, the amount of time to reach key HIV care indicators has become significantly shorter (**Exhibit 4**). For example, median time from diagnosis to first care visit dropped to 4 days in 2017 from 8 days in 2013; median time from first care visit to initiation of antiretroviral therapy dropped to 0 days in 2017 from 27 days in 2013; and median time from diagnosis to viral suppression dropped to 62 days in 2017 from 135 days in 2013.[10]

Exhibit 4: Time to care indicators, 2013-2017.[9] ART = antiretroviral therapy; VSP = viral suppression
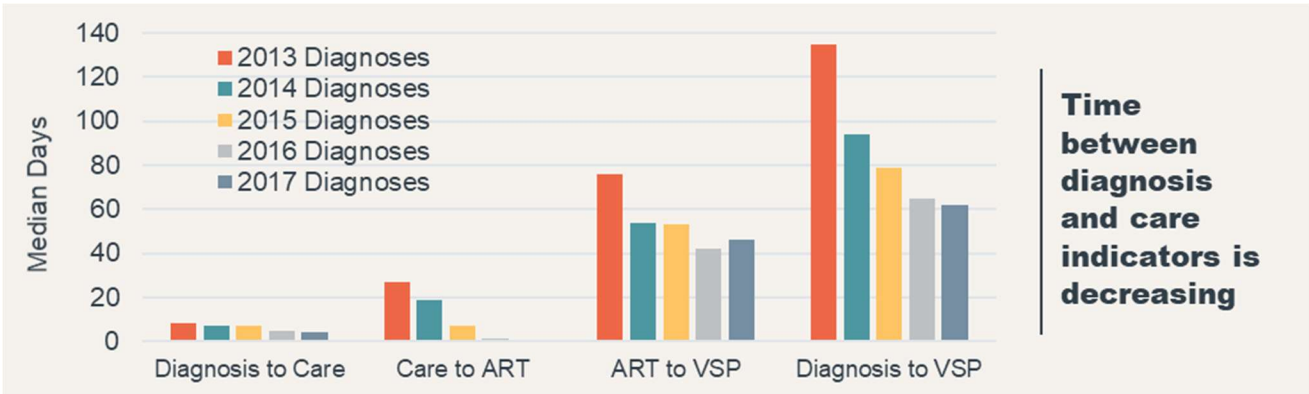
Disparities and Health Inequities

Despite these successes and positive trends, disparities and health inequities in HIV prevention and care are apparent in San Francisco.

Race/ethnicity: Disparities by race/ethnicity, in particular, continue in San Francisco (**Exhibit 5**). While overall new HIV diagnoses have significantly declined in San Francisco since 2013, these declines have been driven primarily by the declines in both the number and proportion of new diagnoses among whites. People of color have not experienced the same rate of decline; in fact, in 2018 new diagnoses increased among B/AA

Exhibit 5: New HIV diagnoses by race/ethnicity, 2009-2018.[9]
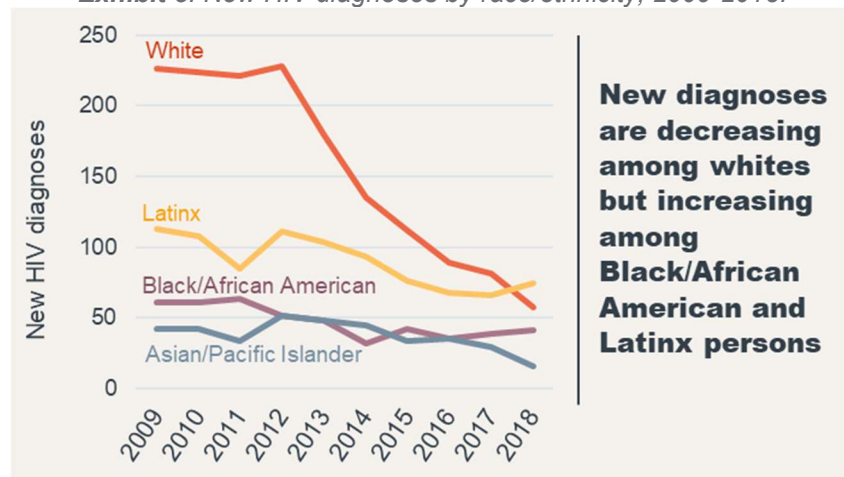
and Latinx persons. And, for the first time, the number and proportion of new diagnoses among Latinx exceeded the number among whites.[11] Interpretation of these data are further complicated by significant intra-group diversity. For example, Latinx is typically collected and reported as a single identity, yet Latinx communities are diverse in terms of foreign-born, U.S. born, and English proficiency, impacting their profile of risk and the types of interventions that may be needed to

---

[9] San Francisco Department of Public Health. (2019). *HIV Epidemiology Annual Report, 2018*. Retrieved from San Francisco, CA: https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/HIV-Epidemiology-Annual-Report-2018.pdf
[10] Ibid
[11] Ibid

address their needs. Many indigenous groups are grouped in with Latinx as well, although they frequently have more differences with Spanish-speaking Latinx groups than similarities.[12]

When population sizes are considered, B/AA men have the highest HIV diagnosis rate among men in the City, followed by Latinos, with rates per 100,000 population of 145 and 89, respectively, compared to a rate of 27 per 100,000 among white men in 2018 (**Exhibit 6**).[13] Similarly, B/AA cisgender women[14] had a much higher HIV diagnosis rate than

Exhibit 6: HIV diagnosis rate in men by race/ethnicity, 2009-2018.[13]

When considering population size, Black and Latino men have the highest HIV diagnosis rate among all SF men

women of all other races/ethnicities in 2018 (35 per 100,000 population compared to 8 and 2 per 100,000 for Latina and white women, respectively).
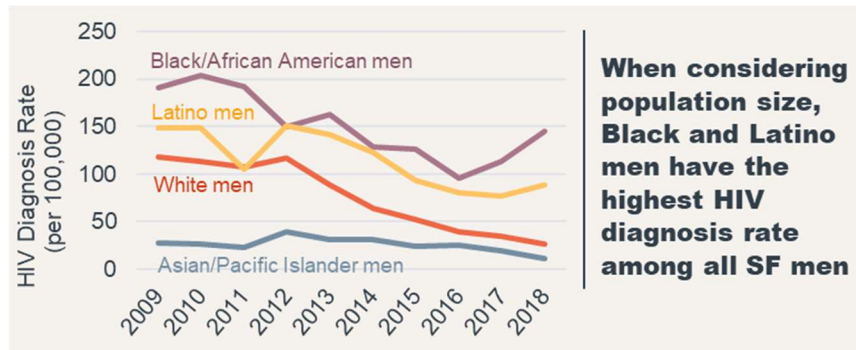
Other examples of relatively poor HIV prevention and care outcomes by race/ethnicity include: B/AA and Latinx PLWH have low levels of viral suppression; 68% and 70%, respectively, compared to 74% for the population as a whole. The mortality rate among B/AA men in 2017 was 148 deaths per 100,000, 1.6 times higher than white men (94 deaths per 100,000) and 2.3 times higher than Latino men (65 deaths per 100,000). Similarly, B/AA women had the highest mortality rate (4.3 times higher than Latina women and 7.2 times higher than white women).[15] When comparing insurance coverage, Asian/Pacific Islanders were most likely to be uninsured at time of diagnosis, 29%, compared to 16% uninsured African Americans, 26% uninsured Latinx, and 20% uninsured whites.

People experiencing homelessness: In recent years, the numbers and proportions of new HIV diagnoses among persons experiencing homelessness have increased (**Exhibit 7**). In 2018, 40 (20%) of new diagnoses were among people experiencing homelessness compared to 29 (10%) in 2015. In addition

Exhibit 7: Homelessness and HIV, 2009-2018.[15]

People experiencing homelessness make up an increasing percent of all SF HIV diagnoses

---
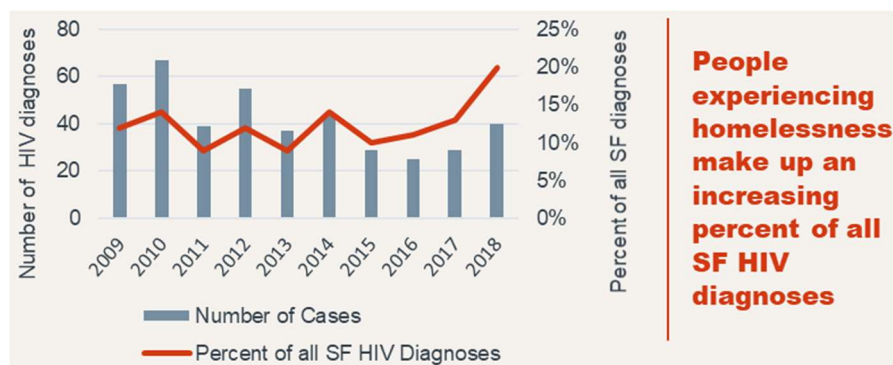
[12] Sanchez, J, Bernd J, Halperin A, Soares RN, on behalf of Case Data Collective. Latinx Community Engagement for San Francisco Ending the HIV/HCV/STI Epidemics. July 2020

[13] San Francisco Department of Public Health. (2019). *HIV Epidemiology Annual Report, 2018*. Retrieved from San Francisco, CA: https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/HIV-Epidemiology-Annual-Report-2018.pdf.

[14] Note that while data reporting of statistics among "women" typically presume cisgender women, if gender options did not include trans during data collection or reporting or if trans women chose to self-identify as women, some trans women may also be included into these categories for each group.

[15] San Francisco Department of Public Health. (2019). *HIV Epidemiology Annual Report, 2018*. Retrieved from San Francisco, CA: https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/HIV-Epidemiology-Annual-Report-2018.pdf.

to increases in new diagnoses, homeless PLWH in San Francisco experience extremely poor health outcomes. For example, homeless PLWH in San Francisco were the least likely to be virally suppressed in 2017, only 33%, compared to 74% overall.[16]

People who inject drugs (PWID) are another population that has not experienced the same gains in HIV prevention and care as other San Franciscans. The number and proportion of diagnoses among PWID has continued to rise; there were 27 (14%) new diagnoses among PWID in 2018 compared to 21 (9%) in 2016. PWID, MSM-PWID, and trans women who injected drugs also had lower viral suppression rates in 2017; 65%, 68%, and 64% respectively compared to 74% overall **(Exhibit 8)**. In addition, survival was poor for PWID. The three-year survival rate was lowest for PWID compared to all other transmission categories; 79% of PWID survived for three or more years following diagnosis, compared to 91% among MSM and 89% overall.[17]

Exhibit 8: *Percent of people who inject drugs (PWID), MSM-PWID, and trans women who had sex with men and injected drugs (TWSM-PWID) virally suppressed in 2017.*[16]
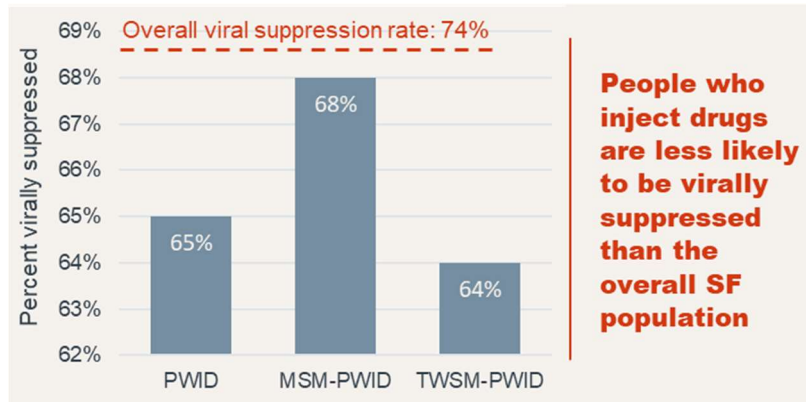
Gender disparities also continue (**Exhibit 9**). Viral suppression among cisgender women living with HIV in San Francisco in 2017 was 66%, and among trans women was 68%, compared to 74% among men. Trans women were also the most likely gender to be uninsured at HIV diagnosis (27%).[18]

Exhibit 9: *Viral suppression in San Francisco by gender, 2017.*[16]
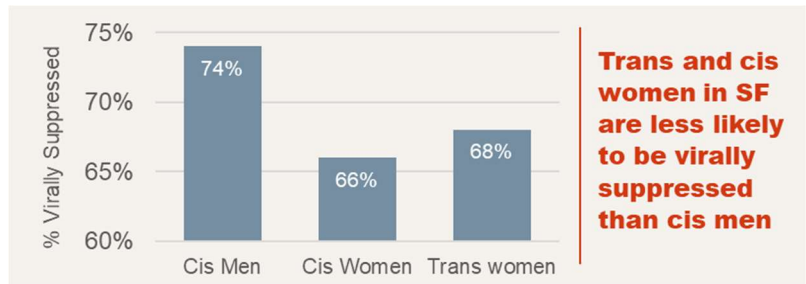
Summary of HIV Epidemiology

The overall decline in new HIV diagnoses and improvements in HIV care outcomes are encouraging and show a positive trend toward achieving the goal of zero HIV infections. However, disparities by race/ethnicity, housing status, transmission risk group, and gender highlight the critical need to address and achieve San Francisco's goal of zero stigma and discrimination, as well as address the housing crisis, if we are to reach zero new HIV infections and zero HIV-associated deaths among everyone.

---

[16] San Francisco Department of Public Health. (2019). *HIV Epidemiology Annual Report, 2018*. Retrieved from San Francisco, CA: https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/HIV-Epidemiology-Annual-Report-2018.pdf
[17] Ibid
[18] Ibid

PART 2: HCV[19]

HCV

1 22,000 SAN FRANCISCANS HAVE HAD HEPATITIS C

22,000

22,000 people—a number equal to the entire population of the Haight neighborhood —have had hepatitis C (are antibody positive).

2 HIGHER AMONG THOSE WHO INJECT DRUGS

68% of active hepatitis C cases are among people who inject drugs, even though they are only 3% of the total population.

3 HIGHER AMONG BLACK/AFRICAN AMERICANS

SF POPULATION

HCV CASES

BLACK/AFRICAN AMERICAN
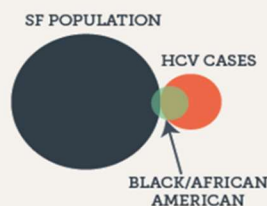
6% of people in San Francisco are Black/African American, yet 31% of HCV cases are among this population.

4 HIGHER AMONG TRANS WOMEN

HCV IN TRANS WOMEN

HCV IN CIS GENDER WOMEN

While 1 in 100 cis gender women are living with HCV, 1 out of 6 trans women are living with HCV.

Background: Hepatitis C (HCV)

Before 2014, HCV treatment was highly toxic, required almost a year to complete, and had a very low success rate. As a result, many people who knew they were living with HCV chose to forgo treatment options and hope they would not experience severe liver damage from decades of unchecked HCV infection. Today, however, curative treatment is widely available in San Francisco, and is easy to take, with short treatment regimens and exceptionally high cure rates. Partially for this reason, in 2015 a group of San Franciscans began meeting and formed *End Hep C SF*, San Francisco's collective impact HCV elimination initiative. Partially as a result of the organizing power of *End Hep C SF*, strong progress has been made to better understand the state of the HCV epidemic, and identify and address the disparities that still exist.

Successes in HCV Testing and Treatment

End Hep C SF estimates that as of 2015, approximately 22,000 residents of San Francisco had antibodies to HCV—this is about 2.5% of all people living in San Francisco that year.[20] Some people with antibodies have cleared the virus naturally or have taken treatments to be cured; an estimated 12,000 people (a little less than 2% of the population) still have active virus in their bodies. People with active virus can transmit the virus to others and their infection may progress toward liver disease; they would benefit from HCV treatment. Many thousand San Franciscans have been treated and cured with new medications (at least 5,302 people were known to have been treated as of the end of 2017), but the exact number is not easy to determine.[21] Unlike with HIV, HCV epidemiology and surveillance in San Francisco has not had a very robust infrastructure for tracking the epidemic, and no systems exist to track treatments outside the SFDPH health network, until recently. In the SFDPH health network, an additional 245 people were treated for HCV in 2018. The true number of active HCV infections could be lower than our estimate, if more people have been successfully cured; *End Hep C SF* is currently preparing to undertake an update of the 2015 prevalence estimate that will give us more accurate and recent estimates of the current epidemic.

---

[19] Ending the Epidemics Steering Committee. Current State of the HIV, HCV, and STI Epidemics in San Francisco, 2019.
[20] Facente SN, Grebe E, Burk K, et al. Estimated hepatitis C prevalence and key population sizes in San Francisco: A foundation for elimination. PloS One. 2018;13(4):e0195575.
[21] Ibid

Part of the key to improving our HCV treatment numbers is ensuring that people living with HCV are aware of their infection and linked to care. In 2018, 5,732 HCV antibody tests were conducted among community-based testing sites in San Francisco.

Exhibit 10: *Percent of HCV antibody tests that were positive in 2018.*[22]
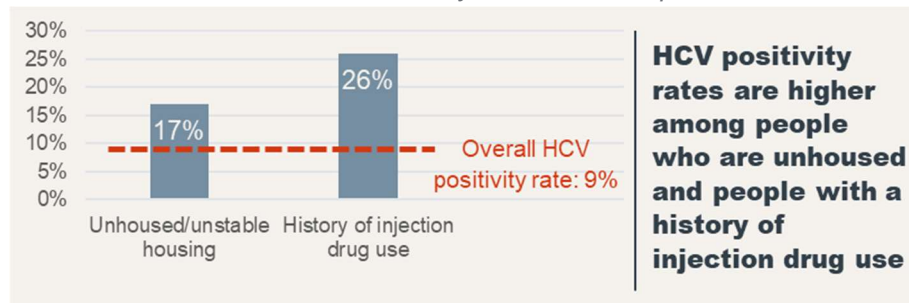
HCV positivity rates are higher among people who are unhoused and people with a history of injection drug use

Twenty-nine percent of these tests were among people with a history of injection drug use (IDU), and 35% were among people who were unhoused or unstably housed. Nine percent of tests overall were antibody positive; however, the positivity rate was 26% among people with a history of IDU, and 17% among people who were unhoused or unstably housed **(Exhibit 10)**.[22]

In 2018, *End Hep C SF* launched a groundbreaking Community Navigator Program in three community-based sites. Community Navigators receive training and support provided in group format, including formal training around HCV disease, treatment and outreach and engagement approaches, and social opportunities to connect and share successes and lessons among peer workers and between peer workers, program staff, and members of *End Hep C SF*. Across three cycles of the Community Navigator program, navigators provided more than 2,100 hours of HCV education with their peers, referred almost 2,700 people to testing and/or treatment, and accompanied 178 people to HCV testing or treatment they might not otherwise have accessed.

Disproportionate Impact of HCV

Some populations in San Francisco are disproportionately infected with HCV. Unfortunately, vulnerable populations, including persons less likely to be engaged in medical care or have access to care, account for the majority of persons living with HCV in San Francisco. In San Francisco the populations most disproportionately impacted by HCV include PWID, people experiencing homelessness or the marginally housed, trans women, African Americans, MSM, and baby boomers.[23]

People experiencing homelessness: People who are unhoused or marginally housed are facing increasingly significant health challenges in San Francisco, especially in recent years as the housing crisis has exploded. This population is also disproportionately impacted by HCV; a study of 246 homeless women in San Francisco between 2008-2010 found that 45% were HCV antibody positive, more than 1 in 4 had never been tested for HCV, and 27% of those testing HCV positive were unaware they had HCV infection.

45% of homeless SF women had antibodies to HCV in a 2008-2010 study

People who were incarcerated were 2X as likely to be living with HCV, in a 2016 study

People who have been incarcerated are also more likely to be living with HCV than people who have not been incarcerated. A study in 2016 found that people who were incarcerated in a San Francisco jail at any point in 2016 were at least twice as likely to be living with HCV than those who were not incarcerated that year.

---

[22] Grinstein, R. Unpublished data, SFDPH, 2019.

[23] End Hep C SF. (2017). *Hepatitis C in San Francisco*. Retrieved from San Francisco, CA: https://endhepcsf.org/san-francisco-hpc-prevalence-estimate/

People who inject drugs: Similar to national and global trends, PWID in San Francisco are particularly impacted by HCV. PWID make up only 3% of the total SF population but account for 68% of active HCV cases (**Exhibit 11**). Significant gaps in HCV care and treatment have been identified among PWID and, as such, PWID are a priority population for HCV-related efforts.[24]

Race/ethnicity: B/AA, while only 6% of the total SF population in 2014, make up 31% of all reported HCV cases (**Exhibit 11**).

Age: Similar to national and global trends, baby boomers (people born between 1946 and 1964) accounted for only 21% of the total SF population but account for 38% of all HCV cases reported to the SFDPH from 2007 to 2015 (**Exhibit 11**).

Sexuality: An estimated 8% of the SF population are MSM, but 14% of active HCV cases are among MSM (**Exhibit 11**).

Gender: While trans women make up only 0.1% the total population of San Francisco, *End Hep C SF* estimates that more than one out of every six trans woman is currently living with HCV.[25] In the recent TransNational study which included 315 trans women in San Francisco, trans

Exhibit 11: Groups disproportionately impacted by HCV.[24]
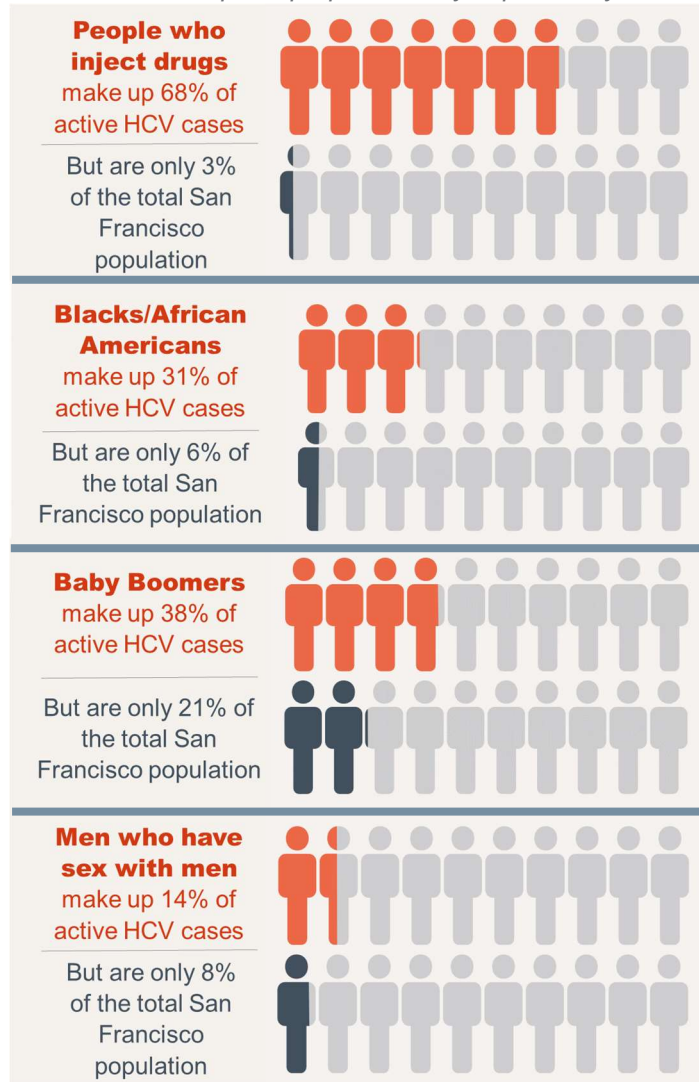
women had a HCV prevalence of 23%, nine times higher than overall San Francisco population.[26] Thirty-nine percent of those living with HCV were also co-infected with HIV, double the overall U.S. rate. Similar to the populations noted above who are disproportionately affected by HCV, HCV

seropositivity was significantly higher among trans women who had ever injected drugs (48.2% vs 9.9%), had smoked crack or methamphetamine (30.8% vs 12.5%), had used intranasal drugs (28.4% vs 15.8%), and had been incarcerated (27.9% vs 9.9%).[27]

---

[24] End Hep C SF. (2017). *Hepatitis C in San Francisco*. Retrieved from San Francisco, CA: https://endhepcsf.org/san-francisco-hpc-prevalence-estimate/

[25] Facente SN, Grebe E, Burk K, et al. Estimated hepatitis C prevalence and key population sizes in San Francisco: A foundation for elimination. PloS One. 2018;13(4):e0195575.

[26] End Hep C SF. (2017). *End Hep C SF Strategic Plan, 2017 - 2019*. Retrieved from San Francisco, CA: http://www.endhepcsf.org/wp-content/uploads/2017/07/EndHepC_FINAL_for_e-distribution.pdf

[27] Ibid

Given the limitations of the HCV surveillance system mentioned above, there may be additional disparities and affected populations in San Francisco not apparent with available data.

HIV and HCV coinfection

People living with HIV are disproportionately impacted by HCV. Globally, PLWH are six times more likely to have HCV than are those without HIV. In San Francisco, it is estimated that 11% of PLWH are co-infected with HCV.[28] HIV-HCV co-infection is particularly high among MSM and PWID.

Despite citywide efforts to increase HCV treatment uptake and successfully curing more than an estimated 5,000 people to date in San Francisco, there are still an estimated 500 to 1,000 San Franciscans who are co-infected with HIV/HCV who need HCV treatment. This includes appropriately 200 who are currently receiving care in the San Francisco Health Network (SFHN), many of whom have substantial barriers to care.[29]

To achieve HCV elimination among PLWH, barriers to care and treatment will need to be fully understood and addressed. Therefore, San Francisco's HCV efforts have included a priority focus on reaching and effectively serving the populations with the highest barriers to treatment and care. Within the SFHN, PLWH with highest barriers to HCV care and cure often have co-occurring medical and mental health diagnoses, and are experiencing housing instability and other socioeconomic challenges. A recent review of barriers among people receiving care at Zuckerberg San Francisco General Hospital's HIV/AIDS clinic found that low engagement (55%), mental health and/or substance use (43%), and housing instability (20%) were the most common barriers to HCV treatment **(Exhibit 12)**.[30]

Exhibit 12: *Percent of HIV/HCV co-infected patients experiencing HCV treatment barriers (n=49).[28]*

Percent experiencing HCV treatment barriers
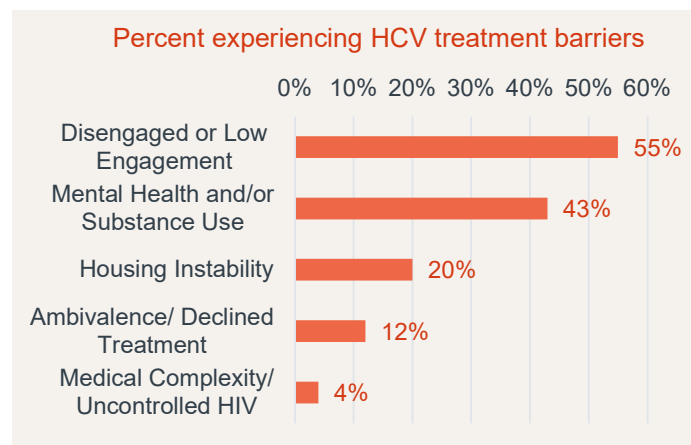
Summary of HCV Epidemiology

Like HIV and STI prevention and care efforts, San Francisco's HCV efforts prioritize reaching and effectively serving populations with the highest barriers to treatment and cure. People co-infected with HCV and HIV are also a priority. Given San Francisco's collective impact HCV elimination initiative described above, eliminating HCV among PLWH is not only feasible but achievable within a modest timeframe of several years.

---

[28] End Hep C SF. (2019) *Elimination of Hepatitis C Virus Among People Living with HIV in San Francisco: Research Results, Recommendations, and Micro-Elimination Implementation Plan.*

[29] Ibid

[30] Ibid

PART 3: STIs[31]

STIs

1 NEW DIAGNOSES ARE RISING

The rates of new syphilis, gonorrhea, and chlamydia diagnoses are increasing while new HIV diagnoses are decreasing.

2 SYPHILIS RATES ARE HIGHER AMONG MEN

MEN WOMEN

Syphilis rates are more than 10x higher in men than women, with the majority of cases among men who have sex with men.

3 SYPHILIS RATES ARE RISING AMONG WOMEN

119

61

2017 2018

While syphilis rates are higher among men, syphilis cases among women have doubled between 2017 and 2018.

4 CHLAMYDIA RATES ARE HIGHER AMONG SOME BLACK/AFRICAN AMERICANS AND LATINX YOUTH

BLACK LATINX WHITE

Chlamydia rates are over 5x higher among Black youth and almost 2x higher among Latinx youth compared to white youth.

Background: Sexually Transmitted Infections (STIs)

During a period when new HIV diagnoses have dramatically decreased, the rate of new syphilis, gonorrhea, and chlamydia cases has continued to rise in San Francisco.

Paradoxically, the gains in HIV prevention which have resulted in dramatic declines in HIV may have contributed to the increases in STIs observed nationally and in San Francisco. Decreases in HIV in San Francisco are the result of a concerted citywide effort to scale-up HIV testing, promote and support early and widespread HIV treatment, a strong linkage to HIV care program, and access to pre-exposure prophylaxis (PrEP). In part because taking PrEP if HIV-negative, or maintaining an undetectable HIV viral load if living with HIV can prevent acquisition and sexual transmission of HIV, condom use has declined. These declines in condom use have therefore likely contributed to rising rates of gonorrhea, syphilis and chlamydia in San Francisco.

Given the increasing and high incidence of STIs in the City, SFDPH is focused on reducing STI health disparities and preventing the most severe complications of STIs by prioritizing work with:

1 Gay, bisexual, and other men who have sex with men (MSM)

2 Adolescents and young adults, particularly those of color

3 Trans persons, and

4 Cis gender females of reproductive age who are at risk for syphilis infection (and therefore newborns with congenital syphilis).

It is important to note that, across all four of these groups, **B/AAs experience higher rates of STIs than any other group**,[32] and are also therefore a prioritized population.

---

[31] Ending the Epidemics Steering Committee. Current State of the HIV, HCV, and STI Epidemics in San Francisco, 2019.
[32] Ngyuen T (2020). Unpublished data.

STIs increasing in San Francisco

Exhibit 13: Overall STI rates and HIV diagnoses in San Francisco, 2008-2018.[33]
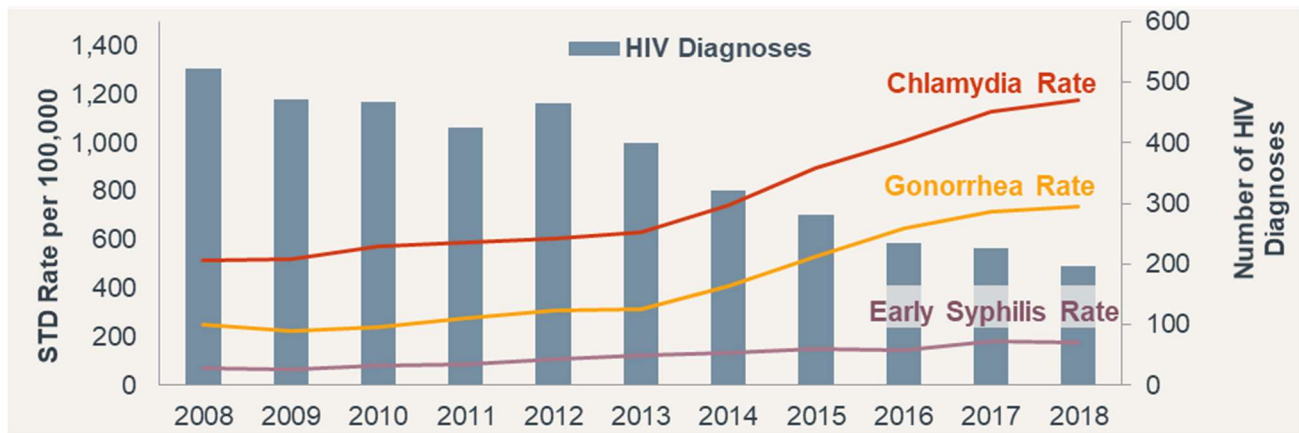
From 2008 to 2018, the number of new HIV diagnoses declined by over 60%, while the rate of Chlamydia increased 244%, rate of gonorrhea increased 195%, and rate of early syphilis increased 157% (**Exhibit 13**). In 2017, San Francisco had the highest early syphilis rate of any U.S. county.[33]

Men make up the overwhelming (95%) proportion of new early syphilis cases; the rate of syphilis among men is 10 times higher than the rate among women (incidence rate for men is 347.8 compared to 29.2 for women; **Exhibit 14**).

Exhibit 14: Syphilis rates by gender, 2018.[33]

Syphilis rates are 10X higher among men in San Francisco, compared to women

Chlamydia cases have also been increasing substantially in recent years; in 2017 the number of reported chlamydia cases was greater than 9,000 for the first time in San Francisco history. This followed a period of rapid increase in new diagnoses when chlamydia diagnoses nearly doubled (4,599 to 9,094) from 2010 to 2017 (**Exhibit 15**).

Exhibit 15: Chlamydia and gonorrhea cases, 2010-2017.[33]

Chlamydia & gonorrhea cases in San Francisco nearly doubled between 2010 and 2017
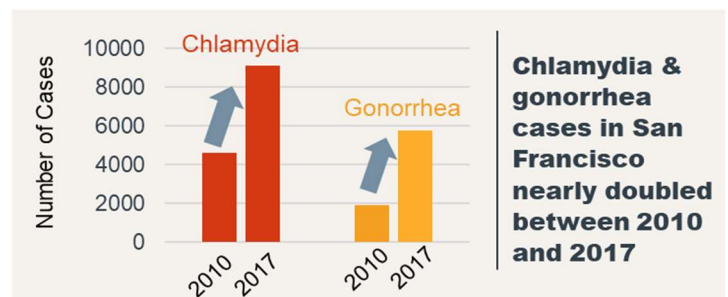
Similarly, the rate of gonorrhea has increased rapidly in recent years, with rates in the San Francisco Metropolitan Statistical Area (MSA) exceeding those in the Los Angeles MSA, the New York MSA, California, and the United States as a whole. Between 2010 and 2017, the number of gonorrhea cases increased by 196% (1,942 to 5,754 cases) in San Francisco. The rate of gonorrhea per 100,000 residents was 714.6 in 2017 and increased by 3% in 2018 to a rate of 736.6. In 2017, over 50% of gonorrhea cases among males in San Francisco were identified through rectal and pharyngeal (throat) infections, highlighting the importance of extra-genital testing in addition to urine/urethral testing.[34]

---

[33] Nguyen T. Unpublished data, SFDPH, 2019.
[34] SFDPH. San Francisco Sexually Transmitted Disease Annual Summary, 2017.

3 cases of congenital syphilis—a preventable condition—were reported in the first three quarters of 2019

Three congenital syphilis cases were reported in San Francisco in the first 9 months of 2019. Although this count of cases is low, it is troubling because congenital syphilis is completely preventable with early testing and appropriate treatment of pregnant females. It also marks a slight uptick from only one reported case in 2017 and zero cases in 2018.

Of the 29 female early syphilis cases reported in 2017, one was pregnant at the time of diagnosis, while 24 were confirmed not pregnant. The limitations of reporting requirements and surveillance do not enable San Francisco to determine the pregnancy status of each female syphilis case or the outcome of each pregnancy.[35] In order to address congenital syphilis, SFDPH activated the Incident Command Structure (ICS) in June 2019. This emergency activation focuses staff efforts on determining pregnancy status and outcomes, in an effort to identify and prioritize pregnant women with syphilis and to avert congenital syphilis cases.

Populations experiencing STI related health disparities

Many of the same populations disproportionately affected by HIV and HCV are also disproportionately affected by STIs.

Race/ethnicity: Racial/ethnic disparities of STIs and related health outcomes remain large. B/AA, and especially youth, are at particularly high risk of STIs. Adolescent and young adult women experience disproportionate rates of chlamydial infection, more so among B/AA youth. In 2017, B/AA youth in San Francisco had 4.5 times higher rates of chlamydia and gonorrhea, and 4.6 times higher rates of early syphilis, compared with white youth.

Chlamydia rates among Black SF youth are nearly 5x higher than among White SF youth

Gender/sexuality: Gay men and other **MSM** have the highest prevalence rates of gonorrhea, chlamydia, and early syphilis. **Trans women** also have very high rates of STIs compared to other San Francisco residents; trans women had positive STI test results almost as frequently as cis men (mostly MSM) at City Clinic in 2017, as can be seen in **Exhibit 16**.[36]

Exhibit 16: Chlamydia and gonorrhea cases, 2010-2017.[36] Most Cis male cases are MSM.

Men who have sex with men and Trans women are at high risk for STIs

---
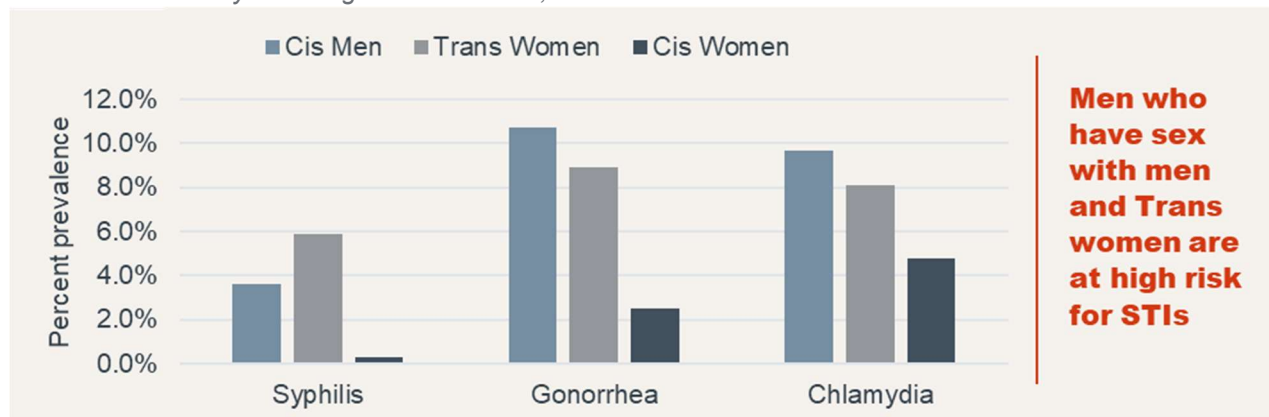
[35] SFDPH, San Francisco Sexually Transmitted Disease Annual Summary, 2017.
[36] Nguyen T. Unpublished data, SFDPH, 2019.

Of particular concern in San Francisco is the rise in **female syphilis cases** in recent years. Although more than 95% of syphilis cases in San Francisco are among men, total syphilis has been rising in women, particularly in vulnerable populations. Syphilis cases among women in San Francisco nearly doubled from 2017 (61 cases) to 2018 (119 cases; **Exhibit 17**) representing a 95% increase.[37]

Exhibit 17: *Syphilis cases among women, 2013-2018.*[37]
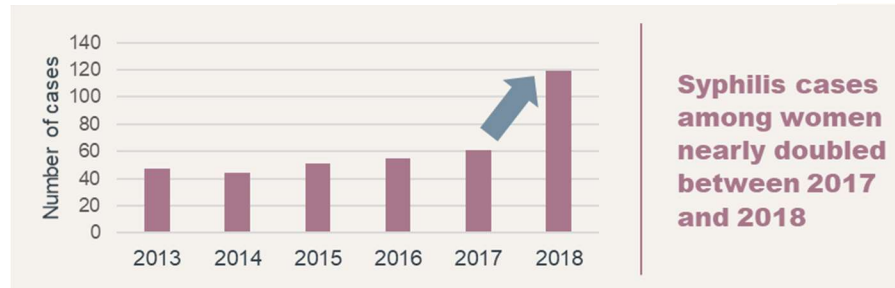
Additionally, in 2019, 158 syphilis cases were reported among women. Twenty percent of the total female syphilis cases reported in the first quarter of 2019 were experiencing homelessness, 36% reported methamphetamine use, and Black/African Americans were disproportionately affected (30% of the cases compared to 19% Latina and 27% white).[38] This is of particular concern because increases in syphilis among women increases the risk of congenital syphilis, a highly dangerous condition which can lead to miscarriages, stillbirth, and neonatal death. Therefore, as might be expected, cases of mother to child transmitted syphilis (congenital syphilis) have been increasing across the country as well in California and San Francisco. In 2017, the U.S. had the highest number of congenital syphilis cases in the past 20 years; California the highest number of cases of any state and the third highest rate of congenital syphilis case behind Louisiana and Nevada. In 2019 in San Francisco, there were four congenital syphilis cases reported, an increase from zero in 2018, one in 2017, two in 2016, one in 2015, and none in 2013 and 2014.

Conclusion from Epidemiological Profile

Given that overlap in the populations experiencing disparities in HIV, HCV and STI prevention, strategies to address these epidemics need to be coordinated and integrated. The interconnectedness of HIV, HCV, and STIs and the related social determinants of health affecting the health outcomes of these diseases, including substance use, mental health, homelessness, poverty, racism, and homophobia among others, demand more fully integrated systems and programs. Integrated services need to become more person centered and wellness focused expanding from an exclusively disease detection and treatment model. They must take into account the multiple, confounding factors that make up a person's identity, including national origin, language spoken, immigration status, as well as sexual orientation, gender identity, and racial identity. An ideal integrated service model would allow a person to get support for all their health and social service needs, whether it's HIV/HCV/STI testing or care, quitting smoking, benefits navigation, or substance use counseling. Integrated service models have great potential to improve both client experience and health outcomes.

These integrated services and coordinated strategies must include efforts to address the social determinants of health including stigma, discrimination, and the housing crisis, to successfully reach, engage and address all the health needs of these vulnerable populations.

---

[37] Nguyen T. Unpublished data, SFDPH, 2020.

[38] Ibid

Section III: Situational Analysis

This section provides an overview of strengths, challenges, and needs related to key aspects of HIV prevention and care in San Francisco. This analysis draws information from a wide variety of sources, including:

- San Francisco EMA HIV Community Planning Council 2017-2021 Integrated HIV Prevention and Care Plan
- End Hep C SF 2017-2019 Strategic Plan and Micro-Elimination Implementation Plan
- SFDPH 2019 STD Strategic Framework
- San Francisco Getting to Zero Consortium 2019 Strategic Plan
- SFDPH HIV/HCV/STD Roadmap: Findings from Stakeholder Engagement (2019)
- SFDPH HIV Epidemiology Annual Report 2018
- SFDPH 2018 Black/African American Health Report
- Plan to Address the PLWH Housing Crisis in San Francisco (in press)
- San Francisco AIDS Foundation Housing in SF: Barriers and Solutions (2020)

PART 1: HIV, HCV, and STI Syndemics

HIV, HCV, and STI Syndemics

A *syndemics* framework is a conceptual framework that situates diseases or health conditions in populations as affected by the factors in which the population is immersed: social, economic, environmental, and political, above and beyond biological factors.[39] Simply put, we cannot address a particular disease (like HIV) in San Francisco without recognizing that the burden of disease falls disproportionately on people who are also negatively affected by racist, classist, sexist, and xenophobic systems. As is clear from the epidemiological profile, HIV, HCV, and STIs are interconnected, they share common root causes, and they are similarly impacted by the social, economic, environmental, and political landscape. It makes sense to address these diseases together from virtually every perspective—this approach is client-centered, cost-effective, and has potential compounded benefits. For example, anecdotally, many people co-infected with HIV and HCV who did not engage in HIV care were motivated to seek HCV treatment once they were re-engaged in care for their HIV, ultimately curing their HCV. In sum, syndemics provides a strong argument for an integrated approach.

One of the challenges for HCV and STI prevention, care, and treatment has been the disproportionate funding and attention on HIV. By leveraging the extensive HIV infrastructure that exists in San Francisco, an integrated approach is already emerging and there are many more opportunities ahead. If the approach to these diseases is better integrated, everyone benefits – clients, providers, funders. HIV can learn from HCV about best practices for serving people who use drugs, and from STI about effective partner notification strategies. Clients get higher quality services, providers develop competencies across all three areas, and funders get more bang for their buck.

---

[39] Syndemics: Health in Context. The Lancet. March 4, 2017: 389(10072), 881.

PART 2: Cross-Cutting Themes

Root Causes: Structural Racism, Cisgenderism, and Economic Inequality

The health disparities that San Francisco experiences in HIV, HCV, and STIs are inextricably linked to a complex mix of social determinants of health, which CDC defines as "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[40] All of these social determinants have the similar underlying root causes. This plan focuses on three underlying causes that are intricately tied to the HIV, HCV, and STI epidemics **economic inequality, cisgenderism, and structural racism (Exhibit 18).**

Exhibit 18: Root causes of health disparities in SF

In the last decade, San Francisco has undergone dramatic economic transformation resulting in rapidly growing economic inequality in the city and in the Greater Bay Area. The impact of this change on the lives of the city's most vulnerable communities cannot be overstated. This shift mirrors a trend toward income inequality throughout the entire state of California, whereby millions are consumed with the daily struggle of managing on extremely low incomes, while at the same time the incomes of higher income households continue to grow.[41]

Inextricably linked is the structural racism embedded in our systems and services, which exclude communities of color from our economic opportunities, increasing their vulnerability and preventing them from experiencing optimal health. Structural racism persists because our systems were fundamentally, and in many cases intentionally, designed to benefit white people and to harm people of color. For example, the practice of redlining, in which neighborhoods where B/AA lived were systematically denied financial lending opportunities. The effects of this practice were pervasive and severe; cutting off these neighborhoods resulted in reduced economic mobility for residents, spawning a cycle of intergenerational poverty, that today manifests as a stark wealth and income gap between B/AA San Franciscans and other groups. Systems designed to penalize immigrants, particularly Latinx immigrants and other immigrants of color, represent barriers to accessing care, for fear that they may get deported and permanently separated from their family. These realities represent chronic stressors that people of color must deal with, not to mention the

---
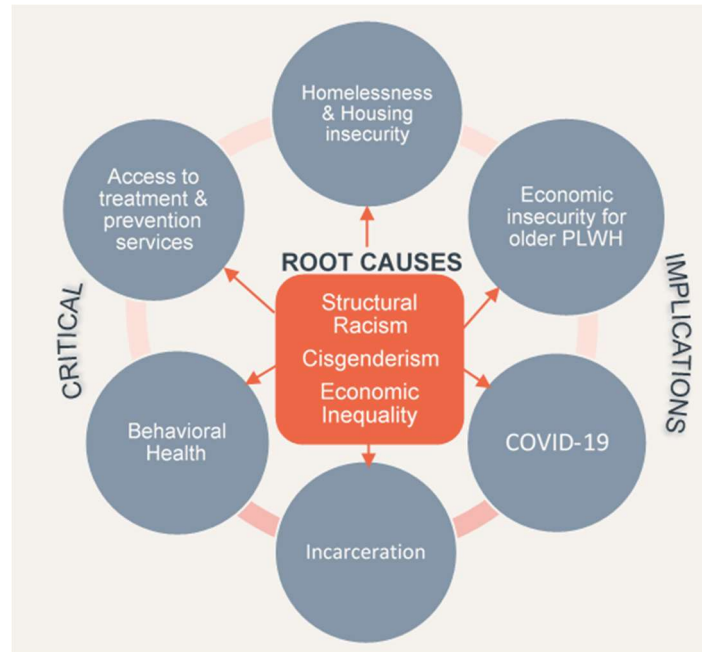
[40] US Centers for Disease Control. Social Determinants of Health. Available at: www.cdc.gov/socialdeterminants/index.htm

[41] California Budget & Policy Center. Income Inequality Significantly Increased for Californians in 2018, and Millions of People Can't Afford Their Basic Needs. Available at https://calbudgetcenter.org/resources/income-inequality-significantly-increased-for-californians-in-2018/

stress and trauma resulting from the multitude of microaggressions they face in daily interactions, and an unimaginable host of other unjust circumstances from police brutality to inferior educational opportunities. It is no surprise that health outcomes across nearly all diseases are poorer among people of color. In fact, B/AAs in the U.S. are more likely to die at early ages from all causes.[42]

These root causes are further reinforced by the outmigration of lower income households and in-migration of higher income households (**Exhibit 19**).[43] These trends mean San Francisco is

becoming more white, people of color who remain in San Francisco are becoming more marginalized, and racial health disparities are exacerbated. As noted in the epidemiological profile B/AA men experience disproportionately high STI rates and B/AA women living with HIV had the highest mortality rate of any racial or ethnic group.
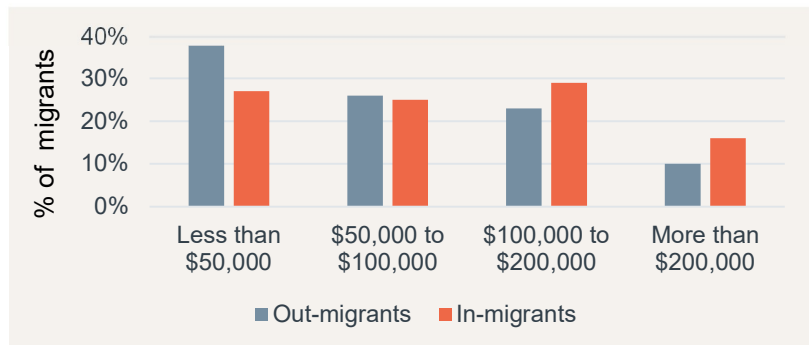
Exhibit 19: Migration by household income group, 2010-2016.[43]

Lastly, as with structural racism, our systems and services are often delivered with a binary concept of gender. This is particularly true outside of HIV, HCV, and STI services, which make explicit (although imperfect) efforts to be inclusive of trans-, non-binary, and gender-non-conforming people. Racism and cisgenderism also compound to create multiple layers of discrimination; in San Francisco, more than half of the trans women in a recent study reporting intersectional (i.e., based on more than one characteristic) discrimination.[44]

Exhibit 20: Example of how income inequality impacts HIV in San Francisco.

Relatively High Cost of Living

Persons at 300% of poverty or below have a much more difficult time surviving in our area than those living at these income levels in most other parts of the United States.[45]

Daily Expenses Unaffordable

Nearly half of all B/AA and Latinx San Franciscans do not earn enough money to meet daily living expenses;[46] 68% of all trans women in a recent study earned less than $36,000 a year.[47]

Housing Instability and Homelessness

An estimated 2,269 people living with HIV (PLWH; 17.8%) are experiencing homelessness or unstable housing; More than 750 of them are age 50 or older.[48]

Insufficient Housing Support

$68,950

To be eligible for HOPWA housing support, PLWH must be at or below 80% of the local median income: $68,950/year for a single person in SF. This sum would be in a high-income bracket in almost any other U.S. region.

[42] Centers for Disease Control and Prevention, African American Health. Available at: https://www.cdc.gov/vitalsigns/aahealth/index.html

[43] Romem I., Kneebone E. 2018. Terner Center, UC Berkeley. Disparity in Departure. ternercenter.berkeley.edu/uploads/Disparity_in_Departure.pdf

[44] Beltran, T., Allen, A. M., Lin, J., Turner, C., Ozer, E. J., & Wilson, E. C. (2019). Intersectional discrimination is associated with housing instability among trans women living in the San Francisco Bay Area. International Journal of Environmental Research and Public Health, 16(22), 4521.

[45] Marin, San Francisco, & San Mateo Counties, California. 2017–2021 Integrated HIV Prevention and Care Plan.

[46] Liu, Amy. 2018. Brookings Institute: "The Urgency to Achieve an Inclusive Economy in the Bay Area." https://www.brookings.edu/research/the-urgency-to-achieve-an-inclusive-economy-in-the-bay-area/

[47] Wilson EC, Turner C, Arayasirikul S, et al. Housing and income effects on HIV-related health outcomes in the San Francisco Bay Area – findings from the SPNS transwomen of color initiative. *AIDS Care.* 2018;30(11):1356-1359.

[48] San Francisco AIDS Foundation. Plan to Address the PLWH Housing Crisis in San Francisco (in press).

Economic inequality, structural racism, and cisgenderism are much discussed in San Francisco, nearly always from a deficit-based perspective. Yet, research shows that by continually talking about, for example, B/AA people and their disproportionate experience with poverty, **we are in fact perpetuating the very racist systems and practices we seek to dismantle.**[49] Part of the challenge for our planning processes and service delivery efforts is to begin to completely reframe our approach to one that is asset-based and affirming—not by "saying nice things" but by bringing forward and lifting up the positive data that never gets talked about, because public heal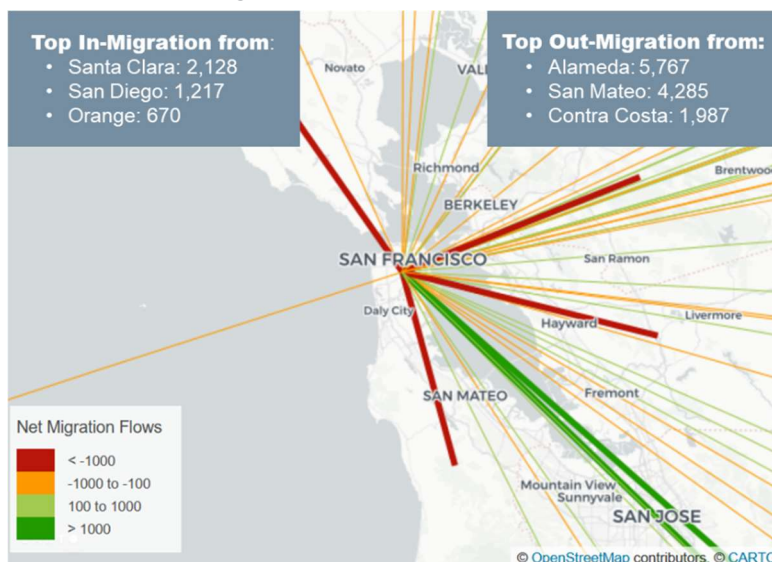th nearly always focuses on gaps. For example, according to a CDC study, Black fathers spend more time in the daily lives of their children than fathers of other races[50]—a finding that flies in the face of all the stereotypes about Black fathers. To dismantle racism (and all -isms) we have to not just reframe, but _correct,_ the narrative to counteract our unconscious biases and ultimately open up opportunities for profound systems change.

HIV, HCV, and STI work cannot solve these root causes, but we can address them head on where they show up in the work. The following six key areas are, in large part, driven by these root causes, and they must be addressed in order to end the HIV and HCV epidemics and make an impact on STI rates. Below we describe each of these cross-cutting themes in further detail.

Cross-Cutting Theme 1: Homelessness and Housing Instability

One of the most profound effects of San Francisco's economic shifts has been a surge in the number of San Francisco residents who are unhoused or unstably housed. In particular, the extremely high cost of housing has produced a wave of displacement that has pushed many middle and working-class individuals and families from San Francisco, especially people of color, to outer areas of the region (**Exhibit 21**).[51] These cities and towns, many not prepared for such a shift, tend to have fewer public resources, services, and job opportunities.[52] San Francisco's Planning

Exhibit 21: _Net Migration in 2015 in San Francisco._[51]

Top In-Migration from:
• Santa Clara: 2,128
• San Diego: 1,217
• Orange: 670

Top Out-Migration from:
• Alameda: 5,767
• San Mateo: 4,285
• Contra Costa: 1,987

Net Migration Flows
- < -1000
- -1000 to -100
- 100 to 1000
- > 1000

Department recently noted that "San Francisco's increasing housing costs have been linked to changes in the city's racial and ethnic composition and concerns about displacement of particular communities of color."[53] During our community engagement efforts, a participant discussed how the rapidly accelerating homelessness crisis was affecting already marginalized communities, breaking

---

[49] Trabian Shorters, Keynote Speech, Collective Impact Convening, June 2020.

[50] Jones, J. Mosher W.D. 2013. National Health Statistics Reports, CDC. Available at: https://www.cdc.gov/nchs/data/nhsr/nhsr071.pdf

[51] Vital Signs. Migration. Accessed June 12, 2020: https://www.vitalsigns.mtc.ca.gov/migration

[52] Bay Area Regional Health Inequities Initiative (BARHII) and Federal Reserve Bank of San Francisco. (2018). "Housing Stability and Family Health." Accessed December 1, 2019: http://barhii.org/wp-content/uploads/2018/09/ Housing_Stability_and_Family_Health.pdf

[53] San Francisco Planning. (2018). San Francisco Housing Needs and Trends Report. Accessed December 1, 2019: https://default.sfplanning.org/publications_reports/Housing-Needs-and-Trends-Report-2018.pdf

up the sisterhood of San Francisco's tightly knit trans women:

> *"…I've lived here since 1985. I've never seen a girl sleep on the streets until recently. That's not been a part of our community…We never let our people be out on the street or sleeping in the alley. And now we're at that level. I fear for the girls. I've heard the stories of what happens to them there."*

In San Francisco, people experiencing homelessness represent a large percentage of those diagnosed with HIV, HCV, and STIs. In 2019, 1 in 5 people diagnosed with HIV were homeless at the time of diagnosis,[54] and people experiencing homelessness are much more likely to be living with HIV than people who are housed. Among 246 homeless women surveyed in San Francisco in 2008-2010, 45.9% were HCV antibody positive and 61.1% of those people were also HIV-positive. More than 1 in 4 of those surveyed had never before been tested for HCV, and 27.4% of those testing HCV positive were unaware they had HCV. While this study focused on women, men make up the majority of HCV infections in San Francisco, so it is reasonable to extrapolate that rates among unhoused men are even higher.[55] Finally, 32% of women diagnosed with syphilis in 2018 in San Francisco were experiencing homelessness at the time of diagnosis.[56]

Being homeless or marginally housed is strongly and unequivocally linked to poor health outcomes among people living with HIV (PLWH).[57-60] Among those diagnosed with HIV in 2017, 83% of those who were housed achieved viral suppression within 12 months after diagnosis, compared with only 53% of those who were homeless.[61] Detectable viral load results in an increased likelihood of transmission to others, and since being housed is associated with higher rates of viral suppression, housing is also a prevention tool. Yet viral suppression among unhoused PLWH is 33%. Additionally, unhoused PLWH have higher rates of hospital utilization and substance use.[62] This population experiences

Exhibit 22: Housing and HIV.

- In 2019, 1 in 5 people with HIV were unhoused at the time of diagnosis

- In 2017 only 53% of people experiencing homelessness were virally suppressed within 12 months of diagnosis, compared with 83% of people with housing

- 11% of people experiencing homelessness are living with HIV – that's an estimated 2,269 people

- Another 1,056 to 3,128 PLWH are at risk for losing their housing

---

[54] San Francisco Department of Public Health (2019). HIV Epidemiology Annual Report 2018. Available at: https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/HIV-Epidemiology-Annual-Report-2018.pdf

[55] Page, K.M., et al. HCV screening and infection awareness in a cohort of HIV-infected and uninfected homeless and marginally housed women in San Francisco, CA. Poster presentation, The Liver Meeting. American Association for the Study of Liver Diseases, 2016.

[56] SFDPH, Unpublished data, 2019.

[57] Aidala AA, Wilson MG, Shubert V, Gogolishvili D, Glovberman J, Rueda S, et al. Housing status, medical care, and health outcomes among people living with HIV/AIDS: A systematic review. *American Journal of Public Health*. 2019 Jan; 106(1):e1-e23.

[58] Wilson EC, Turner C, Arayasirikul S, Woods T, Nguyen T, Lin R, et al. Housing and income effects on HIV-related health outcomes in the San Francisco Bay Area – findings from the SPNS transwomen of color initiative. *AIDS Care*. 2018 Nov; 30(11):1356-1359.

[59] Galárraga O, Rana A, Rahman M, Cohen M, Adimora AA, Sosanya O, et al. The effect of unstable housing on HIV treatment biomarkers: An instrumental variables approach. *Social Science Medicine*. 2018 Oct; 214:70-82.

[60] Kalichman S, Hernandez D, Kegler C, Cherry C, Kalichman MO, Grebler T. Dimensions of Poverty and Health Outcomes Among People Living with HIV Infection: Limited Resources and Competing Needs. *Journal of Community Health*. 2015 Aug; 40(4): 702-708.

[61] San Francisco Department of Public Health (2019). HIV Epidemiology Annual Report 2018. Available at: https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/HIV-Epidemiology-Annual-Report-2018.pdf

[62] From SFDPH OPT-IN, unpublished data, 2019.

severe co-morbidities and barriers to care in addition to homelessness, including diagnoses of alcohol disorder (39%), drug use disorders (49%) and psychoses (30%). Community engagement participants stated that people experiencing homelessness face stigma within healthcare settings from providers, staff, and other clients. Providers minimize their concerns in a way they don't think would occur if they were housed. In addition, they often don't feel welcome in these spaces due to lack of access to spaces where they can clean themselves. This fear of rejection by healthcare providers can mean people experiencing homelessness avoid accessing healthcare altogether.

Residential Care Facilities for the Chronically Ill: In San Francisco, five Residential Care Facilities for the Chronically Ill (RCFCIs) currently receive Housing Opportunities for People with AIDS (HOPWA) and other city funding to support the care of PLWH and other complex medical and social needs. RCFCIs were established in California during the early part of the AIDS crisis to provide less-expensive, congregate care for PLWH to 1) combat homelessness due to anti-HIV stigma, and 2) provide specialized HIV care. At that time, RCFCIs in large part provided end-of-life care, but as treatments have improved, this has expanded to become a transitional housing model.

While people currently living in RCFCIs share a common HIV diagnosis, their presenting issues are increasingly related to age, homelessness, mental health and/or substance use disorders and the interplay between them. These co-morbidities may not necessarily be caused by HIV, but co-exist with HIV to create challenges to maintaining safe housing in which to receive appropriate whole-person care.[63] While congregate living facilities of this type are no longer in favor, they serve a key role in ensuring housing for a select group of PLWH in San Francisco's critically challenged housing market. However, a recent Mayor's Office of Housing and Community Development (MOHCD) report noted a concern that residents are becoming "stuck" in RCFCIs because of a lack of available affordable housing for those for whom it is appropriate, undercutting the primary role of RCFCIs as transitional housing.[64]

Housing as health care: Due to the huge impact of housing on health outcomes, housing is considered by many in the Bay Area and elsewhere to be health care. Housing is an indispensable link in the chain of prevention, care, and treatment for people with HIV, HCV, and STIs; without adequate, stable housing it is virtually impossible for individuals to access primary care, adhere to medications, and preserve overall health and wellness. It is clear that San Francisco cannot get to zero without addressing homelessness in our city. Except for HOPWA, until fairly recently the HIV and housing worlds have been siloed in San Francisco until now. Given the increasing crisis of homelessness in our city overall and particularly among PLWH, it is critical that these silos be broken down, allowing for further integration and collaboration.

The links between homelessness/housing instability and race cannot be ignored. B/AAs represent 6% of SF's population, and 37% of unhoused people.[65] Racial discrimination by landlords prevents people of color from acquiring and keeping their housing.[66] According to the San Francisco Planning Department, 65% of San Franciscans are renters, compared to 45% in the greater Bay Area. In addition, in 2015, nearly half of B/AA SF households renting their housing were considered

---

[63] San Francisco Mayor's Office of Housing and Community Development. (2020). Strategic Assessment of HOPWA-Funded Residential Care Facilities for the Chronically Ill (RCFCIs).

[64] Ibid

[65] Applied Survey Research. *San Francisco Homeless Count & Survey Comprehensive Report.* San Francisco Department of Homelessness and Supportive Housing;2019.

[66] Moore E, Montojo N, Mauri N. Roots, Race, and Place: A History of Racially Exclusionary Housing in the San Francisco Bay Area. Berkeley, CA: Haas Institute for a Fair and Inclusive Society, University of California, Berkeley; October 2019.

to be "rent burdened" or "severely rent burdened," paying more than 30% or 50% of their income in rent, respectively.[67] In 2018, 36% reported being unstably housed in the previous 5 years, and a full 30% reported not having any housing options if they were forced out of their current residence.[68]
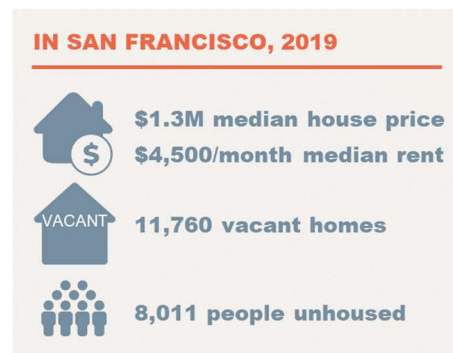
The COVID-19 pandemic is likely to exacerbate San Francisco's homelessness crisis. A recent MOHCD report[69] quoted a Los Angeles Times article predicting that the number of homeless Californians could increase by 20% because of job loss secondary to COVID-19.[70] In addition, COVID-19 has had a disproportionate effect on those with the smallest safety net—those who are already unhoused or at risk of losing housing, B/AA and Latinx families, and PLWH, among others. San Francisco has put policies in place to protect those most at risk of losing housing during this critical time, including temporary moratoriums against rent increases and evictions, and an extended time to pay missed rent; however, once these legal protections expire people will remain at risk of eviction. For San Francisco to fully live its health department's stated values of **advancement of health equity and racial justice**, and **valuing human dignity**, addressing systemic racism as it relates to housing and homelessness must be part of the equation.

Barriers to adequate housing in San Francisco

Exhibit 23: Housing in SF. [71,72,76,77]

Property Cost: As of January 2019, the median list price of houses on the San Francisco market was $1.3 million, averaging $1,108 per square foot—a cost that has approximately doubled over the past decade.[71] The median rental price in San Francisco is around $4,500—a cost approximately one third-higher than the San Francisco-Oakland-Hayward Metro average.[72]

IN SAN FRANCISCO, 2019

$1.3M median house price
$4,500/month median rent
11,760 vacant homes
8,011 people unhoused

Financial Disincentives: Property owners may be financially disincentivized to offer affordable housing. For example, wealthy foreign and local investors buy units in the San Francisco housing market (often with all-cash payments),[73] but often do not use these units as primary residences, instead leaving them vacant (defined as livable residential housing units (a) having no one living in it at the time of interview or (b) as a residence where occupants have usual residence elsewhere),[74] or "flip" them into non-affordable housing.[75] In 2019, this contributed to an estimated 11,760 vacant homes in San Francisco[76] a number 47% higher than the estimated population of people who were unhoused (a conservative

---

[67] San Francisco Planning Department. *San Francisco Housing Needs and Trends Report.* July 2018.

[68] Ibid.

[69] San Francisco Mayor's Office of Housing and Community Development. (2020). Strategic Assessment of HOPWA-Funded Residential Care Facilities for the Chronically Ill (RCFCIs).

[70] Oreskes, B. Mass unemployment over coronavirus could lead to a 45% jump in homelessness, study finds. LA Times, May 14, 2020. https://www.latimes.com/homeless-housing/story/2020-05-14/coronavirus-unemployment-homeless-study-increase-45-percent

[71] Zillow. San Francisco Home Prices & Values. https://www.zillow.com/san-francisco-ca/home-values/. Published 2020.

[72] Ibid

[73] Cal Matters. Data dig: Are foreign investors driving up real estate in your California neighborhood? Published 2018. https://calmatters.org/housing/2018/03/data-dig-are-foreign-investors-driving-up-real-estate-in-your-california-neighborhood/.

[74] US Census Bureau. Definitions and Explanations. https://www.census.gov/housing/hvs/definitions.pdf.

[75] SF Weekly. How Much S.F. Real Estate Do Wealthy Foreign Buyers Own? Published 2019. https://www.sfweekly.com/news/how-much-s-f-real-estate-do-wealthy-foreign-buyers-own/.

[76] Mercury News. How many vacant houses are there really in the Bay Area? Published 2020. https://www.mercurynews.com/2020/01/05/how-many-vacant-houses-are-there-really-in-the-bay-area/.

estimate of 8,011 in 2019[77]). Although San Francisco requires owners of vacant properties to self-report and register with the City, this system lacks accountability; only 38 residential properties were on this registry in May 2017.[78]

The Airbnb industry also contributes to the vacant housing situation. As of 2020, Airbnb reported more than 7,000 listings in San Francisco. Of these, 62% were entire homes or apartments, and 58% had "high availability" (available for more than 90 days per year), suggesting they were relatively unlikely to be used as full-time residences.[79]

Inability to boost affordable housing: Limited subsidies and other incentives to boost affordable housing act as a third barrier. The City's Affordable Housing Bonus Program provides incentives beyond the federal low-income housing tax credit,[80] rewarding developers with increased density and height relative to existing zoning regulations.[81] However, community engagement suggests that although developers are interested in building affordable housing projects, they are often dissuaded by the slow, complex, process of engaging with the City in potential partnerships.

Eviction: Another barrier to stable housing among San Franciscans is eviction, according to community engagement participants. Current federal vacancy regulations, in which units not occupied for 90 days must be opened for another person, mean that emergency, low-income, and subsidized housing can be lost when individuals enter inpatient treatment facilities, forcing an impossible choice between substance use or mental health treatment and having a place to live. In addition, people with substance use disorders are often unnecessarily evicted from housing, going against San Francisco's commitment to harm reduction and improving the health of people who use drugs.

Temporary vs. permanent solutions: Finally, community engagement findings also suggest that the City's continuing focus on expanding temporary shelter options such as navigation centers—while critically needed given the crisis situation—has overshadowed the commitment to permanent, sustainable housing. There has, however, been some strong local community and government motivation around housing regulation. In July 2019, a coalition of approximately 50 San Francisco organizations, ranging from community-based organizations, to tech companies, to the San Francisco Giants, announced their intention to secure 1,100 currently vacant housing units in all 11 City districts for people who are unhoused to live in.[82] In 2017, a new short term rental law went into effect in San Francisco, placing increased regulation on Airbnb by requiring all short-term rental properties be formally registered with the City to ensure that listings comply with short-term rental law;[83] the City has even prosecuted Airbnb landlords who violate the short-term rental laws.[84]

[77] Applied Survey Research. *San Francisco Homeless Count & Survey, Comprehensive Report, 2019.* San Francisco, CA: SF Department of Homelessness and Supportive Housing (DHSH); 2019.

[78] SF Chronicle. Should SF tax empty homes and buildings? Published 2017.
https://www.sfchronicle.com/business/networth/article/Should-SF-tax-empty-homes-and-buildings-11306541.php.

[79] Inside Airbnb. Adding data to the debate. Published 2020. http://insideairbnb.com/san-francisco/.

[80] Office of Policy Development and Research. Low-income housing tax credits. Published 2019.
https://www.huduser.gov/portal/datasets/lihtc.html.

[81] San Francisco Planning. Affordable Housing Bonus Program (AHBP). Published 2020. https://sfplanning.org/ahbp.

[82] KQED. New Campaign to Reduce Homelessness in San Francisco Aims to Find and Fill Vacant Housing Units.
www.kqed.org/news/11763567/new-campaign-to-reduce-homelessness-in-san-francisco-focusses-on-finding-existing-housing-units.

[83] Reuters. Airbnb, San Francisco settle lawsuit over short-term rental law. Published 2017. https://www.reuters.com/article/us-airbnb-sanfrancisco-settlement-idUSKBN17X254.

[84] Tech Crunch. SF fines two landlords $2.25 million for illegal Airbnb rentals. Published 2018. https://techcrunch.com/2018/11/05/sf-fines-two-landords-2-25-million-for-illegal-airbnb-rentals/.

San Francisco is poised to be the first city in the country to achieve the "Getting to Zero" vision of zero new HIV infections, zero HIV-related deaths, and zero HIV-related stigma. However, **we cannot get to zero unless we ensure that people living with and at risk for HIV have safe, stable housing, and we cannot house people living with and at risk for HIV unless we address the root causes of the housing crisis in our city**, which affect thousands of unhoused or unstably housed people. To address this issue, the San Francisco Department of Housing and Community Development (MOHCD) established an HIV Housing Workgroup, which developed the City's *2020-2025 HIV Housing Plan*.[85] Highlights of this plan are shown below (**Exhibit 24**), and have been incorporated into this EtE Plan.

Exhibit 24: Highlights of 2020-2025 HIV Housing Plan

Goal	Strategy
1. Maintain current supply of housing/facilities dedicated to PLWH	**1A**. Identify alternative funding sources for capital improvements and operating support for HIV Housing
2. Increase supply of housing/facilities dedicated to supporting PLWH	**2A**. Expand available supportive housing by developing 10 new units for PLWH and gain additional units through strategies such as master leasing and gaining new private landlords that will accept HIV rental subsidies
3. Expand resources available for subsidizing/ making & keeping housing more affordable for PLWH	**3A**. Revisit the balance of deep vs. shallow rental subsidies to ensure maximum efficiency of these references **3B**. Increase emergency eviction prevention assistance programs for PLWH through legal assistance, one-time back rent payment, and other means
4. Expand access to services for PLWH that help increase housing stability	**4A**. Leverage other housing support resources (e.g., VA, HSA, etc.) **4B**. Ensure access for PLWH to mental health/substance abuse services **4C**. Ensure access to aging services for PLWH through collaboration/ coordination with aging services providers **4D**. Expand access to other needed services for PLWH (education, job placement, medical, etc.)
5. Improve efficiency and quality of the housing and service delivery system	**5A**. Increase mobility between levels of care in residential settings **5B**. Enhance coordinated intake and referral system, and case management for housing and related support services for PLWH **5C**. Ensure that services and resources and culturally appropriate **5D**. Improve coordination between efforts within the City of San Francisco designed to support PLWH **5E**. Increase the number of HIV housing service trainings available to HIV housing related service providers

---

[85] City of County of San Francisco, Mayor's Office of Housing and Community Development. 2020-2025 Housing Plan Strategies and Goals; draft April 2020 (not final at time of printing).

Cross-Cutting Theme 2: Behavioral Health

Behavioral health in this plan is inclusive of substance use, mental health, and interactions between the two. Substance use has long been identified as a driver of new HIV, HCV, and STI infections. In San Francisco, four substances in particular have been widely acknowledged to contribute to the spread of HIV: alcohol (heavy use), cocaine, methamphetamine, and poppers.[86] Opioids also play a major role, particularly given the recent increases in fentanyl use, contributing to dramatic spikes in opioid overdose. For those already infected with HIV, substance use can hasten disease progression and negatively affect adherence to treatment. Substance use is known to play a similar role in HCV and STI transmission and treatment, particularly through the sharing of injection equipment in the case of HCV. Risk for HIV, HCV, and STI transmission is further affected by complications of changing drug use patterns and the interactions of increasing rates of homelessness and increased overdose risk. Though overdose from opioids and fentanyl has been much-discussed nationally, since 2008, deaths determined to have been caused by a methamphetamine overdose in San Francisco climbed from 1.8 per 100,000 people to 14.6 in 2018, or 126 deaths.[87] During San Francisco's 2019 Methamphetamine Task Force,[88] local subject matter experts expressed frustration over the lack of substance use treatment options for people who do not want to abstain completely from use of all substances, and emphasized the need for a greater number of low-threshold options for substance use treatment.

In addition to challenges related to problematic substance use, some people living with HIV, HCV, and/or STIs struggle with mental health disorders due to pre-existing psychiatric conditions, co-occurring substance use disorders, challenging living environments, or simply due to the negative impact of societal stigma. Segments of society at highest risk for contracting HIV may already have a higher prevalence of anxiety, depression, and a history of substance use. Regardless of its origins, the presence of significant emotional distress and/or a psychiatric disorder in people living with HIV, HCV, and/or STIs can be an obstacle to staying healthy. Mental health disorders can impact medical treatment by negatively affecting medication adherence and overall participation in medical care and by interfering with engagement in healthy activities. For those who are able to access residential mental health and substance use treatment, 44% are discharged to shelters or the streets.[89]

44%

of people completing residential treatment in SF are discharged to shelters or the streets.

In San Francisco, access to culturally appropriate behavioral health services is an essential component of HIV, HCV, and STI prevention and care. But that access is still limited for many of the people who most need it. For instance, in research done for the current *End Hep C SF* HIV/HCV co-infection micro-elimination plan, medical providers in the city reported that the most common primary barriers to HCV treatment among people co-infected with HIV and HCV were disengagement or low engagement in care (29%) and barriers associated with mental health or

---

[86] HIV Prevention Planning Council (2010). San Francisco HIV Prevention Plan.

[87] San Francisco Department of Public Health (2019). Counts of accidental overdose deaths involving cocaine, methamphetamine, or opioids in SF, CA 2006-2018.

[88] San Francisco Department of Public Health, Methamphetamine Task Force. Last Accessed October 12, 2020. https://www.sfdph.org/dph/comupg/knowlcol/MethTaskForce/default.asp

[89] Hiramoto K. Budget Meeting. San Francisco Board of Supervisors; May 1, 2019.

substance use (28%).[90] A further review of barriers identified for people receiving care at Zuckerberg San Francisco General Hospital's HIV clinic found that low engagement and mental health and/or substance use were the most common barriers to HCV treatment.[91]

A particular challenge to addressing substance use and mental health among people living with and at risk for HIV, HCV, and/or STIs is that the current structure of behavioral health services, particularly privatized services, is often not best suited to meet the needs of these populations. While the California's expansion of Medicaid (called Medi-Cal) under the Affordable Care Act substantially expanded access to behavioral health services for PLWH and people with mental health needs, challenges and gaps remain. For example, accessing non-specialty mental health services can be difficult and many substance use programs are effectively abstinence-based even if they theoretically operate within a harm reduction framework. While there has been a trend to more integrated mental health/substance use treatment given the frequent co-occurrence, funding streams and services are still often siloed. The Roadmap identifies an important opportunity for San Francisco to integrate behavioral health services and overdose prevention with HIV, HCV, STI services—and in particular to integrate harm reduction approaches more deeply into behavioral health services.

Cross-Cutting Theme 3: Access to Treatment and Prevention

Tens of thousands of people who are living with or at risk for HIV, HCV, or STIs are served by San Francisco-based systems every year. However, it is becoming increasingly clear that those who access these systems are those people who are capable of doing so—and this is not everyone. For some, administrative or logistical barriers make it impossible to engage in the services they need. For others, eligibility or payment requirements do not match their current situation or budgets. People who have experienced a high degree of trauma have often developed maladaptive coping mechanisms that are sometimes at odds with the requirements of treatment in a traditional medical setting. Ongoing stigmatizing behavior towards people experiencing or perceived to be experiencing homelessness will keep people from seeking care. And for some, previous stigmatizing treatment episodes due to racism, homophobia or transphobia, and harsh judgment toward and/or rejection of people who use drugs result in avoidance of care programs, for fear of being re-victimized. Simply put, more low-threshold options are needed for treatment and prevention services in San Francisco, and structural changes are required to ensure that services are harm reduction-based and trauma informed, and delivered with a racial equity and harm reduction lens.

While Medi-Cal allows the city to leverage state dollars to fund certain types of drug treatment, statutory limitations on reimbursable services, transportation to stabilization facilities, and eligibility requirements for benefits prevent optimal use of state funds to support treatment for many who need it most.[92]

To be accessible, services need to be better responsive to logistical challenges and emotional needs of homeless or marginally housed patients. A recent qualitative project with PWID and people

---

[90] End Hep C SF. (2019) *Elimination of Hepatitis C Virus Among People Living with HIV in San Francisco: Research Results, Recommendations, and Micro-Elimination Implementation Plan.*

[91] Ibid

[92] San Francisco Methamphetamine Task Force. Final Report, 2019.
https://www.sfdph.org/dph/files/MethTaskForce/Meth%20Task%20Force%20Final%20Report_FULL.pdf

experiencing homelessness found that in order to improve HIV ART, PrEP, and HCV treatment access among these groups, service delivery models must integrate accessible clinical and social services with protected social spaces for enjoyment and companionship. Most of the items that these individuals carry with them on a day-to-day basis (and risk losing, if separated from them) are not typically allowed in medical facilities or any public closed-door space. A community engagement participant wondered: "We need more programs like HHOME[93] but for all populations. Why does the city wait until we are so sick and traumatized that we qualify for HHOME?"

There are also geographic barriers to care. Most starkly, the Bayview/Hunter's Point neighborhood of San Francisco has by far the highest percentage of B/AA residents in the City, with 29.6% B/AA residents in the Bayview and 53.4% B/AA residents in Hunter's Point, compared to 5.36% in San Francisco overall.[94] This region is especially isolated, with limited public transportation and other structural factors resulting from many years of racist policies, making it even harder for residents here to seek care. While a new state-of-the-art facility being planned to replace the old Southeast Health Center (SEHC) will be big improvement, many of the B/AA residents in the Bayview choose to seek care elsewhere in the city due to privacy or other concerns, but find their options limited by insufficient public transportation options.

In the needs assessment conducted for the 2017–2021 Integrated HIV Prevention and Care Plan, respondents identified numerous challenges and barriers to health and supportive services. Some key areas that respondents "always" or "sometimes" experienced as barriers included: transportation (44%); service hours (42%); cultural sensitivity (19%); and language accessibility (13%). In addition, 21% of survey respondents met the criteria for being homeless - including 4% living on the streets or in a car—and 12% of respondents did not have health coverage of any kind.

Finally, **immigration status** can be a significant barrier to accessing care. Immigrant communities may be unfamiliar with healthcare systems in San Francisco and can require additional navigation support geared to this challenge. Undocumented Latinx immigrants and those seeking sanctuary or applying for citizenship may fear the police or ICE, or may fear that using public services will trigger deportation or rejection of their applications. Sometimes, even simply asking people

> "Not many Latinos wanted to get tested [for COVID-19]. They're scared that if they test positive, they're going to be kicked out of the country, so they don't want to test."
>
> Community Engagement Participant

about their race for demographic purposes can trigger that fear, if the counselor or tester is not able to reassure people that it can't be used against them. Without a social security number, people are unable to obtain health insurance, adding yet another barrier to care.

The recently completed Roadmap identified similar needs and pointed to deeper, underlying barriers to effective care and services. Stakeholders named the need for HIV/HCV/STI services to put client and community needs and voices front and center, including directly addressing racial and cultural biases or stigma and discrimination affecting the ways services are delivered. While the SFDPH and its community partners have worked diligently for decades to engage the diverse array of communities most affected by the epidemics, dominant cultural frameworks—particularly white-, male-, and cisgender-centered frameworks—have often been the default for service delivery and

---

[93] HHOME is a program run by SFCHC that provides wraparound services for the highest acuity, most vulnerable PLWH.
[94] Statistical Atlas, statisticalatlas.com

outreach. In recent years, SFDPH has more intentionally used a racial equity lens in order to center communities of color in its work and eliminate racial disparities.

Cross-Cutting Theme 4: New Challenges for Older PLWH

As noted in the Epidemiologic Profile, San Francisco is home to an aging PLWH population – with the majority of PLWH in the city now age 50 and older. This is attributable to the long history of the epidemic in San Francisco, resulting in a large proportion of long-term survivors, as well as to the region's hard-fought success in bringing persons with HIV into care and maintaining their health over time. In addition, San Francisco's overall population is aging, and the City's infrastructure is not fully prepared to meet the needs of older adults. PLWH over 50 by and large have excellent health outcomes; in 2017, between 92-97% of all PLWH over the age of 50 living in San Francisco who were in care were virally suppressed.[95] To continue this trend, there is a need for the local HIV service system to adapt, by improving integration with geriatric medicine, planning for long-term impacts of HIV drug therapies,[96] and being prepared to increase services to address social isolation and the economic vulnerability that often comes when living on a senior fixed income.

A 2010 report, produced by San Francisco's HIV Health Services Planning Council and the Mayor's Long Term Care Coordinating Council[97], described the service needs of the older population living with HIV and offered actionable recommendations for how to address those needs, including:

Physical health, both directly related to long-term HIV disease and related to a host of other comorbidities typically associated with older age;

Mental health, most notably depression and social isolation;

Economic insecurity financial stability, including the challenge of transitioning out of private long-term disability insurance upon retirement; and

Navigating the system of care, in which there is a major lack of healthcare providers cross-trained in both HIV treatment and geriatric care.[98]

In addition, one of the most important findings of the 2010 report was that "the demographic breakdown around gender, race, ethnicity and sexual orientation are diverse and closely mirror the demographics of the overall epidemic in the EMA. It is essential to recognize that as people age, they do not lose the need for services to be delivered in ways that are sensitive to an individual's gender, race, ethnicity and/or sexual orientation." A more recent focus group of San Francisco PLWH ages 50 and older, commissioned by the San Francisco EMA HIV Planning Community Council, noted that "[p]articipants were also concerned that doctors may not be able to differentiate which symptoms are specific to aging versus HIV, and there was general concern regarding the lack of research on the implications of taking HIV medications over long periods of time."[99]

---

[95] San Francisco Department of Public Health. *HIV Epidemiology Annual Report, 2018.* San Francisco, CA: San Francisco Department of Public Health; 2019.

[96] Marin, San Francisco, & San Mateo Counties, California. 2017–2021 Integrated HIV Prevention and Care Plan

[97] San Francisco EMA HIV Health Services Planning Council & San Francisco Mayor's Long Term Care Coordinating Council. (2010). An Emerging Issue HIV/AIDS and Aging in the San Francisco Eligible Metropolitan Area (EMA)San Francisco, San Mateo and Marin Counties. Accessed December 9, 2019: www.sfhivplanningcouncil.org/Documents/docs/HIV%20and%20Aging%20Policy%20Paper%20Final%206.29.10.pdf

[98] San Francisco Campus for Jewish Living (2020). 2019 Community Health Needs Assessment. https://sfcjl.org/pdf/2019-SF-CHNA-Report.pdf

[99] Marin, San Francisco, & San Mateo Counties, California. 2017–2021 Integrated HIV Prevention and Care Plan.

Reflecting these insights, stakeholders engaged for the recent Roadmap document identified an opportunity for San Francisco's HIV services system to coordinate with the Department of Aging to address substance use disorders, mental health, and other health conditions in aging populations.

Cross-Cutting Theme 5: Incarceration

At the broadest level, incarceration—especially the cycle of incarceration, release, and re-incarceration that marks many people's experiences of the criminal justice system -- destabilizes individual lives, families, and communities. Nowhere has this been truer than in B/AA communities, for whom institutionalized racism has manifested in mass incarceration that rapidly escalated 25 years ago and continues today. Partially for these reasons, the San Francisco Health Commission recently took a stance on incarceration as a public health issue,[100] directing the SFDPH to develop proposals to prevent incarceration, improve data and analysis, expand discharge planning and coordination within and outside the department among programs that serve the populations most impacted by incarceration.

San Francisco has a projected average daily county jail population of 1,289 individuals for the 2019-20 fiscal year. That reflects a steady, decade-long decline from more than 2,100 individuals in 2008—and is the result of intentional efforts by local criminal justice, law enforcement, and human services agencies to divert people from incarceration when possible and to strengthen supports for people reentering society after detention. Despite this progress, the demographics of San Francisco's incarcerated population reflect broader national and statewide disparities and perpetuate gross inequities along racial lines, with 50% of the San Francisco jail population in 2014 being B/AA despite the city's overall demographics that year of only 6% B/AA.[101]

HALF of SF's jail population is Black/ African American

In addition, San Francisco's jail system, like many others in the country, houses a large population of people living with mental illness and/or struggling with substance use. A 2016 report prepared for the San Francisco District Attorney's Office noted that "between 35 and 40 percent of individuals detained in San Francisco jail receive care from Jail Behavioral Health Services and 15 percent are treated for a serious mental illness. These individuals are presenting with more severe mental illnesses and more acute symptoms than ever before."[102]

Within this context, the SFDPH and its partners have found both a high burden of HIV, HCV, and STIs and elevated risk for transmission among the people involved in San Francisco's criminal justice system. For instance, HCV antibody screening in San Francisco jails has yielded an antibody positivity rate of 10%.[103] However, data show that it's not incarceration itself that puts

---

[100] Kagan, R. SF Health Commission recognizes incarceration as a public health issue.
https://pretermbirthca.ucsf.edu/news/sf-health-commission-recognizes-incarceration-public-health-issue
[101] City & County of San Francisco, Office of the Controller. Update to the Jail Population Forecast, June 16, 2015.
https://sfcontroller.org/sites/default/files/FileCenter/Documents/6516-FINAL%20Forecast%20Report%206.16.15.pdf
[102] Haney C, Johnson J, Lacey K, Romano M. Justice That Heals: Promoting Behavioral Health, Safeguarding the Public, and Ending Our Overreliance on Jails. Last accessed December 5, 2019:
sfdistrictattorney.org/sites/default/files/Document/BHJC%20Concept%20Paper_Final_0.pdf
[103] Marin, San Francisco, & San Mateo Counties, California. 2017–2021 Integrated HIV Prevention and Care Plan.

people at risk for those diseases, it's that incarceration affects the same people who are at increased risk due to the social determinants of health that are at the root of both issues.[104]

Incarceration creates significant challenges to effective prevention and added burdens for HIV, HCV, and/or STI care during the period of detention. For instance, community engagement participants described scenarios where persons who were jailed had been denied preventative care including HIV medications, hormone therapy, and STI treatment. In addition, when individuals go into jail their Medi-Cal (California's Medicaid program) is suspended. This causes discontinuity of care for anyone, but is especially a problem for HCV treatment because medications are particularly expensive and the jail health system has historically been unable or unwilling to pay for them.

In addition, discharge from jail or prison is a critical period that poses numerous health and social risks, including risk for HIV, HCV, and STI transmission; substance use; mental illness relapses; overdose; and homelessness. Given the disruption in treatment commonly experienced during incarceration, individuals living with HIV, HCV, or STIs often struggle to re-engage with care upon discharge. For many, finding stable housing and employment, as well as complying with the terms of release, take priority over seeking medical care.

Cross-Cutting Theme 6: The Effects of COVID-19

The COVID-19 pandemic has affected every aspect of this Ending the Epidemics Plan, from community engagement activities to plans for future service provision. The highly contagious nature of COVID-19 highlights the effects of social and economic inequities on health outcomes. In San Francisco, the neighborhoods with the highest rate of cumulative COVID-19 cases as of October 14, 2020 are Bayview/Hunters Point, the Tenderloin, the Mission District, and Visitacion Valley. These are areas with many communities of color, and some of the highest proportions of low-income residents in the city. Bayview/Hunters Point has the highest rate of cases at 397.4 per 10,000 residents, followed by the Tenderloin at 335.6 per 10,000 residents.[105] The Latino Task Force for COVID-19 and UCSF partnered to create the testing initiative called *Unidos en Salud*, to provide testing to residents and workers in a single census block, 16-square block section of the Mission District. The infection rate in that single census block was 11 times higher than the city average.[106]

The Latinx community in San Francisco has been especially hard hit by COVID-19; despite making up only 15.2% of the population, 49.6% of all COVID-19 cases in San Francisco were among Latinx residents as of October 14, 2020.[107] With the pandemic shutting down hotels, restaurants, and hostels, many Latinx workers have lost their jobs and thus their ability to pay for housing, or the housing itself. Limited and crowded housing means that many Latinx people are unable to safely quarantine, leading to household transmission as confirmed by viral genetic sequencing.[108]

---

[104] Spaulding, AC, *et al.* HIV and HCV in U.S. Prisons and Jails: The Correctional Facility as a Bellwether Over Time for the Community's Infections. *AIDS Reviews.* 2017, Oct-Dec; 19(3): 134-147.

[105] Data SF, Neighborhood COVID-19 data: https://data.sfgov.org/stories/s/Map-of-Cumulative-Cases/adm5-wq8i#cumulative-cases-map, October 14, 2020.

[106] Daube, E. "An Epidemic of Inequality," *UCSF Magazine,* 2020.

[107] Data SF, Population Characteristics for COVID-19: https://data.sfgov.org/stories/s/w6za-6st8

[108] Chamie, G. *et al*. (2020) Community Transmission of Severe Acute Respiratory Syndrome Coronavirus 2 Disproportionately Affects the Latinx Population During Shelter-In-Place in San Francisco. *Clinical Infectious Diseases*, August 21, ciaa1234.

Moreover, because they are often working essential jobs that cannot be performed remotely, many Latinx and other people of color are at much higher risk for exposure to COVID-19. As one community engagement participant put it, "they don't have COVID because they're Latinos. They have more COVID because of their working and living conditions."

The unhoused population of San Francisco has also been disproportionately impacted by COVID-19, with 3% of all cases in <1% of the population.[109] One week before San Francisco's March 16 Shelter In Place order, Mayor London Breed announced an allocation of $5 million for measures to protect unhoused people and residents of SROs from the novel coronavirus. Simultaneously, the Public Health Officer issued an order requiring cleaning and contagion protocols in SROs and other facilities like navigation centers.[110] At the same time, however, resources such as food pantries, drop-in and respite centers, and clinics reduced services and hours, removing vital supports from those who desperately needed them. Many providers increased their street outreach presence to maintain regular, in-person contact with existing clients who could no longer access the spaces and services they relied upon. When people experiencing homelessness were moved to isolation and quarantine hotels, they were not given an option for where they would be relocated, and were frequently moved far from the communities they had established on the street.

Exhibit 25: *Laboratory-based HIV testing, San Francisco, Jan – June 2020[111]*

HIV, HCV, and STI prevention, testing, and care services have been very heavily impacted by COVID-19 and the Shelter in Place order. Community-based testing and linkage services for HCV were halted in March, and only gradually began to restart in the summer months, at much lower levels than had been seen previously. HIV services at San Francisco AIDS Foundation's Magnet clinic at Strut—including PrEP, testing, and care—dropped more than 90% from January 2020 to April (**Exhibit 25**).[111] Laboratory-based HIV testing counts from hospitals and other healthcare facilities also sharply dropped from normal levels in January to a nadir in April, and are still slowly rebounding (**Exhibit 26**).[112] The number of new PrEP prescriptions at Kaiser

Exhibit 26: *Magnet Services, Jan 2019 – June 2020[112]*

---

[109] Data SF, Population Characteristics for COVID-19: https://data.sfgov.org/stories/s/w6za-6st8

[110] Bay City News. SF Mayor Announces $5M Fund to Protect Homeless from Coronavirus. Available at: https://www.nbcbayarea.com/news/local/sf-mayor-announces-5m-fund-to-protect-homeless-from-coronavirus/2251362/

[111] Hare B. HIV and COVID-19. Presentation to the Getting to Zero Consortium. San Francisco, September 27, 2020.

[112] Ibid

Permanente in Northern California, which had been steadily climbing each quarter since 2014, dropped 59% from Quarter 1 of 2020 to Quarter 2 (**Exhibit 27**).[113] Most of the youth-focused health clinics in San Francisco closed for safety upon issuance of the Shelter in Place order, and as of October 1, 2020 had not yet re-opened. The impact these closures and service stoppages have had on HIV, HCV, and STI incidence and outcomes like HIV viral suppression have yet to be realized, but preliminary data are concerning.

During EtE community engagement activities, community members noted that access to medications has been much more difficult during the pandemic. Virtual provision of routine healthcare became the "new normal," but technology use varies dramatically among priority

Exhibit 27: New PrEP Prescriptions at Kaiser Northern California[113]

New PrEP prescriptions at Kaiser dropped 59% during the first three months of the COVID-19 pandemic.

populations. Many community members may only have limited access to a landline telephone, with their ability to use technology limited by cost, device life, lack of WiFi, or theft. Still others are unable to access technological services in their native language or don't have confidence in the security of the devices. Regardless of the cause, lack of access to cell phones, laptops, internet, or electricity creates a barrier to healthcare in a virtual world. As one community engagement participant described, the "new normal" isn't accessible to everyone.

Moving forward, there are significant concerns about what will happen to the communities relocated in response to COVID-19. Community members and providers alike wonder what will happen to people who have become accustomed to living indoors or in a secure space who are summarily returned to the streets—will the transition exacerbate mental health issues or substance use? Will they be unable to continue to take their life-saving medications on a daily basis? These concerns must be addressed in order to continue ending the epidemics even in a post-COVID world.

Despite the dire impact that COVID-19 has had on people at risk for and living with HIV, HCV, and STIs in San Francisco, there has been much attention focused—especially since summer—on the best ways to restore services and recover progress toward ending the epidemics. These concerns were the main focus of a Getting to Zero consortium meeting in September 2020, and have been an ongoing part of End Hep C SF workgroup meeting discussions since Spring. In October the San Francisco Community Clinic Consortium released a set of protocols and guidelines to help regain lost ground in HIV viral load suppression, clinic-based screenings for HIV and STIs, and PrEP, developed by a number of medical directors in the Consortium. Much of the first year of implementation funding under CDC's PS20-2010 will be dedicated to assessing and redesigning HIV, HCV, and STI services that make sense in the "new normal"—not just for those who have virtual access to providers, but also for those on the other side of the digital divide.

---

[113] Hare B. HIV and COVID-19. Presentation to the Getting to Zero Consortium. San Francisco, September 27, 2020.

PART 3: Current Needs, Strengths, and Challenges by Pillar

This situational analysis highlights key existing strengths and challenges in San Francisco's efforts to advance an integrated approach to achieving the combined goals of getting to—and staying at— zero new HIV infections, zero HIV-related deaths, and zero stigma; eliminating HCV as a public health threat; and reversing increasing STI rates in the city.

The tables on the following pages help to outline the current needs, strengths, and challenges for ending the HIV, HCV, and STI epidemics in San Francisco, organized by pillar. In addition to the pillar-specific challenges identified in the tables, particular attention to workforce development is needed, as it is a major challenge that cuts across all four pillars.

Cross-Pillar Challenge: Workforce Development

Given the extreme economic inequality and un-affordability of SF, both the SFDPH and its local nonprofit partners have struggled with maintaining a workforce with relevant qualifications and experience. This challenge manifests in several ways. First, SFDPH and local nonprofits face difficulty recruiting staff into open positions. Notably, individuals who have traditionally held direct service and/or program management roles at various organizations increasingly live outside SF due to displacement and thus face long commutes; in some cases, they also struggle to make ends meet on wages that no longer keep pace with the region's high and still rising cost of living. For example, while the MIT Living Wage Calculation for a single adult with two children in San Francisco is $46.75 an hour,[114] a typical average wage for a social work case manager at a RCFCI is $25.60/hour, and the wage for a facilities or food worker is only $18.19/hour.[115] Second, once staff are hired, organizations face the difficulty of retention. Retention is a challenge for many of the same reasons as recruitment. However, the workplace is a cultural setting like any other, where privilege predicts success. Thus, organizations struggle to support and retain staff who are hired specifically because they have *not* lived lives of privilege, and thus have relevant life experience and direct connection to the marginalized communities most affected by the epidemics. Investing in developing a workforce pipeline from affected communities into settings that will allow them to thrive is both the right thing to do and an effective upstream HIV/HCV/STI prevention strategy in its own right, because it addresses the root causes of economic inequality, structural racism, and cisgenderism. However, it takes significant organizational resources and culture shifting to make the workplace supportive to the success of all workers, regardless of the societal privilege granted by their birth zip code, ethnicity, or socioeconomic status. While many organizations provide trauma-informed care and recognize the needs of *clients* from marginalized communities, their workplace policies and environments are often not trauma-informed; effectively ignoring the needs of the full diversity of their workforce.

It is not an exaggeration to suggest that San Francisco's health and social services sector is on the brink of workforce crisis. The challenges are particularly acute when it comes to behavioral health— it is very difficult to find psychiatrists, therapists, and case managers, and even more difficult to find people of color with these professional backgrounds, as well as those who can deliver services in Spanish and other languages for Latinx clients, such as Brazilian Portuguese and the indigenous languages of Central America, or Asian clients, including Vietnamese, Tagalog, and Cantonese.

---

[114] MIT Living Wage Calculation for San Francisco County, California, https://livingwage.mit.edu/counties/06075
[115] San Francisco Mayor's Office of Housing and Community Development. (2020). Strategic Assessment of HOPWA-Funded Residential Care Facilities for the Chronically Ill (RCFCIs).

SF has made some progress on the workforce development front. SF has embraced the Anchor Institution movement,[116] looking to large nonprofit institutions that are unlikely to ever move from their location (such as UCSF or Zuckerberg San Francisco General Hospital (ZSFG)) to improve stability in the workforce. This is just one example of SF's large institutions embracing their leadership role related to community workforce development, with the goal of improving the long-term health and welfare of the communities in which they are based. The Office of Economic and Workforce Development (OEWD) has made large investments in workforce development programs throughout the City. However, there is no collective impact approach to workforce development and retention, resulting in fragmented micro-efforts that do not fundamentally change the status quo.

In the Roadmap, stakeholders responded to all these challenges by identifying the need to **build a highly skilled cross-trained workforce that reflects the populations served, has low turnover rates, and is valued and supported.** Community engagement participants expressed wanting to receive services from "folks with lived experience," "folks from the street," "people with experience in the drug world," and people from "their own race/culture." One participant explicitly stated that there should be "less folks with education only" providing services, and summed it up by saying, "If care comes from people like me, I would trust the system more." Hiring people whose expertise is being from and deeply knowing the communities being served must be a key pillar for any successful workforce development effort in San Francisco.[117]

San Francisco will consider best and promising practices for workforce development, such as to:

- Consolidate multiple workforce development and retention micro-efforts under one umbrella.
- Increase organizational capacity to train, hire, retain, and promote people from under-resourced communities, especially those who can provide behavioral health services for Latinx or Asian clients for whom English is not their preferred language.[118]
- Build strong linkages between SFDPH, CBOs, and workforce development programs.
- Evaluate and improve workplace climate, through rooting out institutional racism and other forms of discrimination.[119]
- Work to strengthen the education pipeline for under-resourced communities.[120]
- Provide robust and ongoing training and support to staff from the populations served (e.g., group training, one-on-one coaching, counseling services).[121,122,123]
- Provide mentorship opportunities for new hires with payment for mentors.[124]

---

[116] Community-Wealth.org. Overview: Anchor Institutions. Available at: https://community-wealth.org/strategies/panel/anchors/index.html

[117] Toma L, Kwan M, Franza, K, Mazarai M, on behalf of San Francisco Community Health Center. People Experiencing Homelessness and Housing Instability Community Engagement for San Francisco Ending the HIV/HCV/STI Epidemics. July 2020.

[118] Pinderhughes R, Bui A, Alexander B, King B, McCaffery E, Onda T. Advancing Health Equity in San Francisco: An Assessment of UCSF's Anchor Institution Capacity and Recommendations for Strategic Direction. 2019.

[119] Ibid

[120] Ibid

[121] Ibid

[122] Armenta A. Community Navigator Pilot Program, End Hep C SF 2018 Annual Evaluation: Results and Lessons from End Hep C SF's Third Year. 2019.

[123] Chang AR, Large NT, Tseng PN, on behalf of the Adolescent Health Working Group. End the Epidemics: Recommendations for Funding Innovative HIV/HCV/STI Services for Youth Experiencing Homelessness. San Francisco, December 2019.

[124] San Francisco Mayor's Office of Housing and Community Development. (2020). Strategic Assessment of HOPWA-Funded Residential Care Facilities for the Chronically Ill (RCFCIs).

- Make continuing education affordable and valuable for people without professional degrees, via incentives like course credit, the same way CEUs are offered to doctors and nurses.[125]

- Avoid any tendency to assume that people from under-resourced communities cannot or do not want to pursue higher education or have an ambitious career path. This means opening doors to a wide variety of opportunities for self-determination. One community engagement participant observed that there is a dearth of representation across professions, leading to substandard care: "They have never been poor or Black so why should they care?"[126]

- Create a trauma-informed workplace, not just trauma-informed services, to allow workers who have learned and developed essential knowledge and skills for the job through adversity to thrive.[127]

- Address job stress through group meetings and social work assistance for staff.[128]

- Compensate staff equitably and commensurately with cost of living.[129]

- Prioritize long-term paid roles over short-term temporary positions, internships, and stipended volunteers, unless designed to be pathways to permanent paid positions.[130] Funneling community members who have a great deal of expertise into anything less than sustainable positions that pay a living wage is not only insufficient, it's unjust and counterproductive to creating a viable stable workforce. How people are paid/employed communicates to them, and others, what their value is. As noted by participants in the trans community engagement efforts, having a permanent paid job can be an enormous boost to a person's self-worth, in addition to their economic stability.[131]

- Abandon traditional "top-down" models of training and service delivery led by non-community experts; instead adopt the Freirean idea that learners are also teachers and must co-develop programs, curricula, messaging and services for them to be effective.[132]

- Diversity and excellence go hand in hand. Avoid a "tokenization" approach to staffing—just because someone is from the community being served does not mean they are the right person for the job, and/or do not require further training.[133,134]

---

[125] Sanchez, J, Bernd J, Halperin A, Soares RN, on behalf of Case Data Collective. Latinx Community Engagement for San Francisco Ending the HIV/HCV/STI Epidemics. July 2020.

[126] Mizrahi Jackson G, on behalf of AIDS Project of the East Bay. African American/Black Community Community Engagement for San Francisco Ending the HIV/HCV/STI Epidemics. July 2020

[127] Sanchez, J, Bernd J, Halperin A, Soares RN, on behalf of Case Data Collective. Latinx Community Engagement for San Francisco Ending the HIV/HCV/STI Epidemics. July 2020.

[128] San Francisco Mayor's Office of Housing and Community Development. (2020). Strategic Assessment of HOPWA-Funded Residential Care Facilities for the Chronically Ill (RCFCIs).

[129] Chang AR, Large NT, Tseng PN, on behalf of the Adolescent Health Working Group. End the Epidemics: Recommendations for Funding Innovative HIV/HCV/STI Services for Youth Experiencing Homelessness. San Francisco, December 2019.

[130] Ibid

[131] Toma L, Kwan M, Franza, K, Mazarai M, on behalf of San Francisco Community Health Center. Transgender Women Community Engagement for San Francisco Ending the HIV/HCV/STI Epidemics. July 2020.

[132] Atira. SisterSpace: Shared Using Rooms – Women-Only Overdose Prevention Site. Three Month Developmental Evaluation, August 2017.

[133] Swanson S, Gigante D, Callaghan MI. San Francisco Drug User's Union: Community Engagement for San Francisco Ending the HIV/HCV/STI Epidemics. July 2020.

[134] Sanchez, J, Bernd J, Halperin A, Soares RN, on behalf of Case Data Collective. Latinx Community Engagement for San Francisco Ending the HIV/HCV/STI Epidemics. July 2020.

- Develop specific pipeline programs to diversify the future public health and medical workforce, so that under-served communities have a greater opportunity to receive healthcare and services from people who look like them.[135]
- Make workforce development for diverse employees a key skill for all levels of management.
- Incorporate workforce diversification into transition planning for all mid- and senior-level management positions.

In San Francisco, workforce development best practices need to be accompanied by addressing the local economic barriers, through creative solutions such as subsidized housing for people of color, trans persons, youth, and other groups who want to work in public health in San Francisco but who have not had equal access to the economic opportunities of the local booming economy.

One particular challenge is worth noting that is specific to tight-knit communities. Community members want to receive services from people who are from their community, but not necessarily people they *actually know.* For example, for many trans women, work and personal life are tightly intertwined, creating complexity in provider/client interactions if the two know each other. Boundaries can become blurred, and clients may worry about the potential disclosure of private information to their personal networks.[136] This challenge has also been highlighted among B/AA communities where everyone more or less knows each other – clients want to get services in their own backyards from people who look like them, and at the same time, they don't want to risk encountering a provider who knows them.

In summary, San Francisco's future success at getting to zero for HIV, eliminating HCV, and reducing STIs relies heavily on our ability to recruit and retain a diverse public health and medical workforce. Very few of our proposed innovative efforts will ever come to fruition without the people to carry them out. And our ability to recruit and retain a diverse workforce is strongly dependent on our ability to address root causes—(1) the structural racism and other -isms that pervade our health institutions and prevent people of color and people from marginalized populations from entering/staying in the work, and (2) the economic inequality that has forced dramatic outmigration of exactly who we need to be the next generation of public health leaders.

Status, Strengths, and Challenges by Pillar

Exhibits 28-31 on the following pages summarize the status, strengths, and challenges for each Ending the Epidemic pillar (Diagnose, Treat, Prevent, Respond). As already noted, workforce development, described above, cuts across all four of these pillars.

---

[135] UCLA Public Health Scholars Training Program. Available at: https://ph.ucla.edu/prospective-students/ucla-public-health-scholars-training-program

[136] Toma L, Kwan M, Franza, K, Mazarai M, on behalf of San Francisco Community Health Center. Transgender Women Community Engagement for San Francisco Ending the HIV/HCV/STI Epidemics. July 2020.

Exhibit 28 | Situational Analysis, Pillar 1: Diagnose

	Current Status	Strengths	Challenges
Summary	People of color and other marginalized communities are disproportionately represented among new cases.	San Francisco has a decades-long track record as a leader in providing HIV testing among the highest risk and most impacted populations.	Despite overlapping epidemics, HIV, HCV, and STI testing is not fully integrated, which compromises access for populations at risk.
Evidence & Examples	- Low undiagnosed HIV (6%) - People with undiagnosed HIV are more likely to be younger and to identify as people of color.[137] - Regular HIV/STI testing considered part of routine health maintenance among many gay men	- Widespread routine HIV testing in medical settings and targeted community-based testing - Dramatic scale-up of HCV testing since the advent of direct-active antivirals, particularly for PWID and people experiencing homelessness - Strong safety net infrastructure - Sex-positive approach to HIV, HCV, and STI testing (e.g., Healthy Penis syphilis campaign, Sex-C brochure) - Capacity for wide and deep reach into communities at risk (encampment health fairs; HCV peer outreach pilot program; venue-based STI testing)	- A dearth of low-threshold, low-barrier options for integrated "one stop shop" testing - Funding restrictions and siloed funding - Limited education about HCV for populations outside PWID - HCV testing not offered everywhere HIV testing is offered - Need for new strategies to ensure RNA testing for people who test HCV antibody-positive - Need improved health department HCV data efforts, including regular publicly-available reporting of HCV epidemiology and implementation of "Data to Care" strategies citywide. - Need to expand STI-specific partnerships (e.g., non-health partners such as youth agencies, the school district, adult probation, and Human Services Agency)[138] - HIV-related stigma and barriers to access - Need more testing/support service staff who are transgender or with deep knowledge of the issues facing trans persons - Need more testing/support service staff with experience being homeless/ marginally housed or who have deep knowledge of the issues facing this community. - Too many late HIV diagnoses, dramatically increasing risk of early death.

---

[137] San Francisco Department of Public Health (2019). HIV Epidemiology Annual Report 2018. Available at: https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/HIV-Epidemiology-Annual-Report-2018.pdf
[138] SFDPH, HIV/HCV/STD Roadmap: Findings from Stakeholder Engagement. 2019.

Exhibit 29 | Situational Analysis, Pillar 2: Treat

	Current Status	Strengths	Challenges
Summary	A large majority of PLWH in San Francisco engaged in treatment in 2018	San Francisco has a sophisticated integrated network of public, university, nonprofit, and private care providers dedicated to delivering treatment for HIV, HCV, and STIs.	Despite significant advances in access to care and advancement of Treatment as Prevention (TasP) strategies for HIV, HCV, and STIs, multiple barriers remain, many of which are structural in nature and related to the social determinants of health, and therefore disproportionately impact people of color and other marginalized groups
Evidence & Examples	• Approximately 81% of PLWH had at least one CD4/viral load test that year.[139] • Among PLWH who were engaged in care, 91% were virally suppressed.[140]	• Robust linkage to care (LINCS for HIV, Community Navigators and CBOs providing navigation services for HCV) • Comprehensive HIV care in the public and private sector • Increase in insurance coverage since passage of the ACA • HCV training and e-consultation for primary care providers in the SF Health Network (safety net)[141]	• Few treatment support options located outside clinic-based settings, to reach the most marginalized populations. • Insufficient medication storage options for people experiencing homelessness • Shortage of physicians skilled in both HIV and geriatric care in San Francisco • Lack of specialized training for HIV case managers in the distinct system of services that exists for persons 50 and older.[142] • Widespread homelessness and housing instability among PLWH and people with HCV • High prevalence of mental illness and substance use among affected populations, creating barriers to treatment and adherence • Gaps in HCV treatment access, (e.g., healthcare providers lack consistent and widespread access to the new treatment formularies, some providers lack knowledge of best practices for treating PWUD)

[139] San Francisco Department of Public Health (2019). HIV Epidemiology Annual Report 2018. Available at: https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/HIV-Epidemiology-Annual-Report-2018.pdf

[140] Ibid

[141] Facente SN, Burk KB, Eagen K, Mara ES, Smith AA, Lynch CS. *Infectious Disease Clinics of North America*. 2018 June, 32(2): 313-322.

[142] San Francisco Department of Public Health (2019). HIV Epidemiology Annual Report 2018. Available at: https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/HIV-Epidemiology-Annual-Report-2018.pdf

Exhibit 30 | Situational Analysis, Pillar 3: Prevent

	Current Status	Strengths	Challenges
Summary	TasP and PrEP have resulted in dramatic decreases in new HIV cases, and new HCV diagnoses are declining as well, although marginalized populations have not experienced equal prevention benefits and are disproportionately impacted. STIs, on the other hand, have been increasing.	San Francisco has invested heavily in the four prevention technologies we have at our disposal: 1) universal and rapid ART, 2) PrEP, 3) syringe access and disposal, and 4) condom access. The results can be clearly seen with the significant decline in new diagnoses in recent years.	The successes of HIV prevention in San Francisco have not been evenly distributed, and in some cases have had unintended consequences that create new prevention challenges.
Evidence & Examples	• 74% of PLWH were designated as virally suppressed (defined as having the latest viral load test within 12 months of HIV diagnosis <200 copies/mL) in 2018.[143] • 644/100,000 San Franciscans use PrEP, the highest rate in the state.[144]	• U=U (undetectable equals untransmittable[145]) messaging • PrEP - uptake and benefits strongest among white MSM • Syringe access & disposal • Harm reduction approach • High levels of knowledge re: HIV transmission due to early and strong community education • Condom access has long been a component of SF's approach	• An HIV prevention infrastructure largely built around the needs of white gay men that does not effectively serve affected communities of color, trans women, PWUD, and people experiencing homelessness • MSM of color have less access to and uptake of PrEP than white MSM[146] • How to maintain sex-positive PrEP messaging and simultaneously address rising STI rates • Persistent chlamydia and gonorrhea epidemic among B/AA youth and lack of funding to serve young men[147]

---

[143] San Francisco Department of Public Health (2019). HIV Epidemiology Annual Report 2018. Available at: https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/HIV-Epidemiology-Annual-Report-2018.pdf

[144] AIDSVu: Local Data, California. 2020. https://aidsvu.org/local-data/united-states/west/california/.

[145] Spinelli M, Gandhi M. Undetectable Equals Untransmittable. UCSF Insite, 2018. Available at: http://hivinsite.ucsf.edu/InSite?page=md-expert-spinelli

[146] Boyer CB. Challenges to STI/HIV Prevention and Screening and PrEP Uptake: Findings from a Local Qualitative Study of Black and Latin/x Young Adult Men and Transgender Women and Healthcare Providers. October 2018.

[147] Boyer CB. Prevention STIs in African American Youth in San Francisco: Findings from a Local Qualitative Study of Youth, Parents, and SFDPH Health Providers and Staff. October 2017

Exhibit 31 | Situational Analysis, Pillar 4: Respond

	Current Status	Strengths	Challenges
Summary	• Plans are in place to rapidly identify and respond to emerging HIV transmission clusters and outbreaks. Secure HIV-TRACE has been implemented to analyze nucleotide sequences and identify molecular clusters, and information and time-space analyses are shared with the Linkage Implementation Navigation Comprehensive Services (LINCS) team. Surveillance and LINCS work together to rapidly identify, locate and link persons in transmission clusters of concern to care and provide testing and linkage to their named partners. Policies are in place for prioritizing rapid intervention and partner services and for time-space analysis. • There are no current outbreaks of or clusters of HCV transmission in San Francisco. For STIs, San Francisco conducts contact tracing/partner notification, and has a particularly robust program for syphilis.	• Long-term collaboration between the HIV surveillance and the LINCS teams. • Established culture of using HIV surveillance data for public health action in San Francisco. • All labs are reporting electronically, most reporting timely • Secure HIV-TRACE is easy to use and highly efficient in identifying HIV molecular clusters. Staff well trained in implementation. • SFDPH has been collecting molecular surveillance sequence data since 2014.	• Molecular HIV surveillance (MHS) sequence data performed at Stanford is not reported to SFDPH or directly to the State Office of AIDS, and so is incomplete. • Most HIV genotypic testing ordered by SF providers is only reported once a month and is not timely. • SFDPH has begun communicating with the HCPC regarding activities and goals for MHS but that work needs to continue to ensure community understanding and support for MHS. • Many people fear of the consequences of partner notification services related to MHS, especially for trans women, people experiencing homelessness, people involved in sex work/survival sex, and/or people who fear experiencing violence from partners.
Evidence & Examples	• A 2018 pilot used HIV sequences and HIV PS data to prioritize 25 not in care (NIC) PLWH from 4 molecular clusters for re-linkage. Over half of the NIC PLWH in prioritized clusters had been previously referred for HIV navigation. Two PLWH were re-linked, both of whom were identified as named partners through HIV PS investigations.	• HIV-TRACE was able to identify and track persons in these clusters of concern. LINCS was able to locate and investigate using trained and available staff. Resources were available to people who wanted to link to care.	• Most NIC patients identified in clusters were previously referred for re-linkage or are loosely engaged in case management. • Molecular data over-selects for patients with a genotype from the past 5 years, duplicating data-to-care efforts. • Some patients were unable to be located • New interventions for patients loosely engaged in care are not available

Section IV: Ending the Epidemics Plan

In order to achieve citywide goals of getting to zero new HIV diagnoses, eliminating HCV, and reversing the rising trend of STIs, San Francisco must build on the excellent work done to date, and take bold new steps to (a) improve focus and responsiveness to the specific needs of communities of color and the related HIV, HCV, and STI disparities they experience, while (b) maintaining existing focus on high prevalence populations—most notably MSM, PWID, and trans women, many of whom are of course also people of color. Particularly, health equity—the elimination of disparities and opportunity for all people to achieve optimal health regardless of identity or geography—requires special effort to improve the health of those who are most negatively impacted by social determinants of health.

The plan that follows first outlines the guiding values and principles that underscore the overall approach. Next, several operating frameworks that directly shape how services are delivered and will be delivered going forward are detailed. Finally, specific plans are outlined by Pillar.

Values and Principles

Over the past three decades, San Francisco's approach to HIV prevention and care has been not only at the cutting edge of science and public health practice, but also rooted in deeply-held values of inclusiveness, compassion, and justice. The San Francisco EtE Plan is built on a strong foundation of principles and values that inFclude the following:

- **Integration of HIV, HCV, and STI prevention, care, and harm reduction.** The key innovation of San Francisco's EtE Plan is the deep alignment of our approach to HIV, HCV, and STIs. Given the interconnectedness of these diseases, and the broader drivers of these diseases such as substance use, mental health, homelessness, poverty, racism, homophobia, sexism and transphobia, to succeed at ending the epidemics we must commit to more fully integrated systems and programs that are person-, not disease-centered.

- **Advancement of health equity and racial justice.** Communities of color and trans people are experiencing disproportionately high rates of new HIV, HCV, and STI infections in San Francisco. The plan recognizes that simply delivering the same services in the same way to all racial, ethnic, and gender groups is neither effective nor just. Among other things, community partners are crucial to plan and implement services that are culturally responsive and humble, provided by a workforce that mirrors the populations served, and places value on the expertise of people with lived experience as part of any priority community.

- **Elimination of stigma and discrimination against people living with and at risk for HIV, HCV, and STIs.** The San Francisco approach not only requires culturally responsive services, it seeks to proactively combat the stigma associated with HIV, HCV, and STIs in the communities most affected. San Francisco seeks to address both client- and community-level stigma by promoting integrated sexual and substance use health messages and providing information on how to access services to promote health and reduce harm. San Francisco will actively seek innovations from community partners to combat stigma and transform perceptions using culturally appropriate, community-informed messages.

- **Ensuring that services are as low barrier as possible.** "Low barrier" means that as few expectations as possible are placed upon clients and potential clients when trying to access

services. In this plan, examples of low barrier services include mobile services; co-located services; drop-in services; express services; and services provided at times convenient for the populations such as nights and weekends. Our plan also leverages the private healthcare system whenever possible. People with private insurance are encouraged and counseled to use their insurance and develop meaningful relationships with primary care providers, while compliance with funding source requirements are maintained.

- **Valuing lived experience with HIV, HCV, and STIs.** Stakeholder and community involvement has been a bedrock component of San Francisco's approach to combating HIV since the earliest days of the epidemic. San Francisco is committed to including community voices, especially of people of color and people with lived experience of HIV, HCV, STIs, homelessness, and substance use, in all aspects of planning, program design, and service delivery. Moreover, people with lived experience must be involved in not just planning but also implementation in substantive—and fully compensated—ways in order to ensure the programs are maximally responsive and effective. Meaningful engagement must be systematic, continuous, and well-supported. As noted in the preceding section, one particular opportunity to fulfill this value is through supporting people from affected communities to enter and persist in the workforce dedicated to ending the epidemics.

- **Valuing human dignity.** The concept of human dignity too often centers on the right to have a safe place to sleep, wash, and use the bathroom, as if that is sufficient. We must think beyond that and consider sharing with our communities the things that bring joy. Regardless of a client's status or circumstances, each client is entitled to the best care we can give them, in spaces that are clean, safe, and desirable. Everyone deserves nice things and pleasure. We must go beyond meeting basic needs to honor each client's unique and special humanity. As one community engagement participant put it: "Kindness should be a prerequisite for employment…We need to put the humanity back in health care."

Frameworks for Planning and Implementation

In addition to these broad principles, San Francisco builds this plan using a number of specific public health and practice frameworks. These essential frameworks include the following:

- **Social determinants of health.** Healthy People 2020 identifies determinants such as "social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships" as strongly influencing health inequities and the health of Americans in general.[148] As the impacts of social determinants of health are more significant for the communities most affected by HIV, HCV, and STIs, San Francisco incorporates social determinants into policy, planning, service delivery, and monitoring efforts.

- **Whole person care.** In the broadest sense, whole person care is predicated on the understanding that the best way to care for people with complex needs is to consider the full range of those needs – including physical, mental, spiritual, social, and economic. The California Department of Health Care Services has undertaken a pilot in counties throughout the state to test the effectiveness of coordinating physical health, behavioral health, and social services in improving health outcomes and reducing medical costs. San Francisco's

---

[148] HealthyPeople.gov. Social Determinants of Health. Last Accessed October 17, 2020: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

whole person care approach builds on an "ecosystem of care" model that emphasizes care coordination across medical, mental health, substance use, housing, and social needs. Early results of the initiative have included improved data sharing across the SFDPH, Human Services Agency, and Department of Homelessness and Supportive Housing (DHSH); strengthened service and benefits navigation for people experiencing homelessness via newly opened Navigation Centers; and outreach to community groups interested in implementing a buprenorphine program in their area.

● **Trauma-informed prevention and care.** Trauma is a critical factor underlying negative outcomes in relation to HIV prevention and care access and retention.[149] Many members of the priority populations for San Francisco's EtE plan have experienced complex, ongoing traumas that make them less likely to seek or maintain care.[150,151,152] Implementation of trauma-informed programs that respond effectively to persons with a history of trauma build trust, empower clients, and improve the experience of people seeking care and support;[153] these types of services have achieved outcomes such as reduced post-traumatic stress disorder symptoms, reductions in problematic substance use, and improved mental health functioning.[154]

● **Harm reduction approach.** The term "harm reduction" is most commonly used to describe a set of practical strategies to reduce negative consequences associated with substance use, though it has also been applied to an array of other health behaviors, including sexual health and even chronic disease. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. The expansion of harm reduction approaches is critical for both reducing the spread of HIV and HCV and for linking and retaining people who use substances in health services.

● **Continuous Quality Improvement (CQI) and Results Based Accountability (RBA).** CQI and RBA are well-established models for strengthening clinical practice and operational effectiveness—both with the aim of ultimately leading to better care and outcomes for consumers of services. The SFDPH has implemented both models in order to rethink, redesign, and improve processes and work patterns.

● **Status neutral planning and services.** SF HIV, HCV, and STI prevention and care continuum strategy reflects a forward-thinking understanding of how to best meet the needs of people living with and at risk for HIV. To this end, the approach builds on the concept of treatment as prevention to prioritizing the needs of people most affected by the epidemics regardless of HIV status. Given that advances in treatment and prognosis have substantially narrowed the gap between the needs of PLWH and those at risk, there are increased opportunities for affected communities to come together around a common vision and set of priorities. These priorities include ensuring access to health care and other services; providing a continuum of HIV prevention, testing, and care and treatment services using a holistic approach; and ultimately getting to zero.

---

[149] Sales JM, *et al*. Trauma-Informed HIV Prevention and Treatment. *Current HIV/AIDS Reports*. 2016 Dec; 13(6): 374-382.

[150] Eaton LA, Driffin DD, Kegler C, et al. The role of stigma and medical mistrust in the routine health care engagement of black men who have sex with men. American journal of public health. 2015;105(2):e75-82.

[151] D'Avanzo PA, Bass SB, Brajuha J, et al. Medical Mistrust and PrEP Perceptions Among Transgender Women: A Cluster Analysis. Behavioral medicine. 2019;45(2):143-152.

[152] Tekeste M, Hull S, Dovidio JF, et al. Differences in Medical Mistrust Between Black and White Women: Implications for Patient-Provider Communication About PrEP. AIDS and behavior. 2019;23(7):1737-1748.

[153] Purkey E, Patel R, Phillips SP. Trauma informed care: Better care for everyone. *Canadian Family Physician*. 2018 Mar; 64(3): 170-172.

[154] Rinker, B. For Women Living with HIV, A Trauma-Informed Approach to Care. *Health Affairs*. 2019; 38(2).

Cross-Pillar Innovative Strategy: Workforce Development

To address the workforce crisis described in the Situational Analysis, San Francisco plans to develop a Community Health Leadership Institute to transform the HIV/ HCV/STI workforce through training and supporting the next generation of public health leaders. The Institute will not be a typical workforce development program, as it aims to fundamentally transfer institutional power to people from communities affected by HIV and related social determinants of health. The Institute will be developed by paid experts, frequently referred to as "peers" or "people with lived experience"—terms that perpetuate a norm of unpaid/low-pay temporary jobs for people who are not "professionals." This effort will radically disrupt that norm and hire experts to give input into, develop, and implement Institute programming.

We believe that envisioning this Institute as a means to shift power into the hands of affected communities will result in the structural changes needed to root out institutional racism, cisgenderism, transphobia, and other forms of oppression, and expand economic opportunities for people who have been excluded from San Francisco's booming economy. The following components are under consideration; these may change once the expert staff are hired:

- **Training** (and linkages to other training/workforce development programs) for people who aspire to work in public health, as navigators, social workers, doctors, case managers, therapists, substance use counselors, program managers, or other allied health professions. While some training may include HIV/HCV/STI content, much of the training will focus on experiential skills-building and problem-solving similar to what one would encounter at a health department or CBO (e.g., assessment skills, how to navigate workplace power dynamics), because many of the people who have the lived experiences that create diversity do not have the cultural experiences necessary to navigate middle-class bureaucracy.
- **Organizational change** will be an integral part of the training and also part of the Institute's mission, with the goal of achieving an anti-racist service system. As such, the Institute will also work with organizations and service providers to identify and change white-centric workplace practices. Similarly, transphobia, homophobia, cisgenderism, ableism, ageism, and other forms of stigma and discrimination will be called out and addressed.
- The Institute will facilitate an ongoing **professional support network** for participants by creating a safe environment to share challenges, solutions, and learning.
- The Institute will serve as both a virtual and physical **workforce development hub**, recruiting from and referring to other programs. For example, the Summer HIV/AIDS Research Program (SHARP) and Sistas Leadership for African American Youth (SLAY) are two SFPDH programs designed to create professional pathways for people from under-resourced communities.
- The Institute's success will be measured through metrics related to CBO/health department workforce diversity, retention, leadership demographics, and workplace satisfaction
- Importantly, the Institute will focus on **pathways to paid permanent jobs** with benefits and a living wage that ensures people can live above the poverty line in San Francisco, not on unpaid internships or short-term stipend projects. We wouldn't ask an Executive Director from a community-based organization with 20 years of experience in the nonprofit field to work for free; why would we ask someone with a decades-long history of drug use who deeply understands community needs to work for free?

With these investments in a sustainable workforce, we are much more likely to succeed with our pillar-specific innovations.

EtE Programs and Key Partners

Over the last decade, San Francisco's HIV testing providers helped to normalize testing as part of regular health maintenance. These strategies proved effective; however, many places offering free and easily-accessible HIV testing still do not routinely offer HCV and STI testing, despite clients continuing to be at risk for these other diseases. Due to the overlapping risk factors for STIs, integrating HCV and STI testing across most sites would create a person-centered holistic approach to sexual health that will help in achieving the city's overarching EtE goals of getting to zero new HIV diagnosis, eliminating HCV, and reducing the number of STIs.

San Francisco has identified **24 new innovative strategies** that will help propel us toward ending the epidemics, across all 4 Pillars. These efforts will require close partnership with several existing as well as new partners to be successful. The programs and partners are described below.

EtE Programs

Exhibit 32: *Summary of EtE Programs and their pillars.*

	ACTIVITY AND DESCRIPTION	DIAGNOSE	TREAT	PREVENT	RESPOND
1	**Establishing one-stop integrated HIV, HCV, and STI testing sites**. We will implement integrated HIV, HCV, and STI testing programs with the goal of greatly reducing barriers to accessing testing for anyone in San Francisco—particularly for communities most greatly affected by and at risk for these diseases. While testing may be the primary driver for these services, our community engagement work suggests that to really meet the needs of our most underserved populations, we should also integrate testing with other basic services, including harm reduction and other substance use services, housing support, legal services, immigration services, and similar.	✓			
2	**Expanding the reach of HIV, HCV, and STI testing efforts through the use of peer-focused programs**. San Francisco values the voices of those with lived experience and is committed to fostering mentorship and peer involvement. We will expand the reach of HIV, HCV, and STI testing efforts through the use of peer-focused programs that hire and support people with lived experience in the priority population(s). The City's HIV/HCV/STI counselor training is an important pathway to more meaningful employment for people with lived experience. San Francisco will seek to replicate and expand the community navigators program started through the *End Hep C SF* campaign and deepen the reach and impact of such efforts by seeking to establish a status-neutral peer program for trans women as well as a program focused on members of the LGBTQ recovery community.	✓			

	ACTIVITY AND DESCRIPTION	DIAGNOSE	TREAT	PREVENT	RESPOND
3	**Expanding or implementing routine opt-out screening in healthcare settings**. We will implement a new framework that more closely integrates healthcare-based HIV testing with PrEP referral or initiation and STI screening. This approach will expand or implement routine opt-out HIV screening in healthcare and other institutional settings located in high prevalence communities, further normalizing and de-stigmatizing testing.	✓			
4	**Increasing rates of yearly HIV re-screening.** We will increase the number of people at elevated HIV risk who are re-screened yearly in healthcare and non-healthcare settings.	✓			
5	**Providing comprehensive linkage and navigation to HIV, HCV, and STI services.** We will enhance the capacity of community partners to work with existing city-run linkage services to ensure that clients are engaged in HIV care; help clients living with HCV to access appropriate programs; and assist clients living with an STI and who do not have access to medical care to be linked to a provider to ensure treatment, with an emphasis on peer-based models of care.		✓		
6	**Delivering same-day diagnosis and treatment for HIV, HCV, and STIs.** A bold new component of our system of care will be to increase the rate of same-day initiation of antiretroviral therapy for the management of HIV throughout our system of care, and to expand same-day treatment initiation to HCV and STIs.		✓		
7	**Supporting re-engagement and retention in HIV care and HCV treatment.** We will explore new ways to provide linkage and retention support that honor our key populations as whole people with many competing needs, and will provide logistical support through things like medication lockers and transportation options.		✓		
8	**Substantially deepening the provision of mental health care for PLWH and people at highest risk for HIV, HCV and STIs.** We intend to make significant progress on this goal by providing access to mental health treatment on demand for those who most need it. This activity will provide access to mental health treatment on demand for those who most need it. We will pilot approaches to expand availability of systemwide access to mental health services including psychiatric evaluation and consultation services for homeless and marginally housed PLWH, both live and through telehealth. We will also seek to expand clinic hours at the San Francisco Behavioral Access Center (BHAC).		✓	✓	
9	**Expanding Substance Use Treatment.** In order to optimize people's health and reduce HIV/HCV/STI transmission, substance use must be addressed in an effective, culturally competent manner that aligns with SFDPH's commitment to harm reduction. We will expand opportunities for on-demand, low-threshold substance use treatment access that adheres to harm reduction philosophies and allows for non-traditional engagement strategies regardless of HIV, HCV, or STI status.		✓		

	ACTIVITY AND DESCRIPTION	DIAGNOSE	TREAT	PREVENT	RESPOND
10	**Greatly strengthening the connection of HIV/HCV/STI testing and treatment to housing-related services.** We envision this connection working in both directions—expanding HIV, HCV, and STI services in settings that serve people who are homeless or marginally housed, while also strengthening access to housing supports such as coordinated entry, housing case management, housing subsidies and service linkages for individuals receiving HIV, HCV, or STI services.		✓	✓	
11	**Accelerating efforts to increase PrEP use.** We will implement a multi-layered strategy to address barriers to PrEP uptake, including regionally with Alameda County.			✓	
12	**Improving PrEP provision to people of color, trans women, PWUD, and people who are unhoused.** We will build on our success in PrEP availability and adoption by continuing our efforts among white gay men/MSM while also directing more resources to communities of color, trans women, PWUD, and people experiencing homelessness, where PrEP uptake has progressed more slowly.			✓	
13	**Expanding PrEP 2-1-1.** We will expand our PrEP 2-1-1 efforts among communities in which PrEP uptake has progressed more slowly, including communities of color, trans women, PWUD, and people experiencing homelessness.			✓	
14	**Better utilizing technology to communicate and engage with people about HIV, HCV, and STIs.** We will develop a unified messaging and community strategy around STIs for our city, and harness technology to improve our use of social and health/wellness apps to provide HIV, HCV, and STI prevention.			✓	
15	**Establishing an STI Community Task Force.** We will establish a short-term Task Force to hold community-led conversations about San Francisco's values and goals around STI prevention and care, and determine realistic solutions to address concerns. We will also expand the contribution of our HIV Community Planning Council to discussions and decisions about STI/HIV integration activities citywide, and will explore the founding of an STI collective impact initiative.			✓	
16	**Improving options for harm reduction in substance use settings.** We plan to expand the availability of substance use treatment models across the continuum of harm reduction services, and improve access to low-barrier medication assisted treatment and comprehensive syringe services programs.			✓	

	ACTIVITY AND DESCRIPTION	DIAGNOSE	TREAT	PREVENT	RESPOND
17	**Implementing overdose prevention strategies.** We will collaborate with the DOPE Project in new efforts to develop onsite overdose response policies and to ensure program participants have unfettered access to Naloxone and overdose prevention and response trainings.			✓	
18	**Increasing rates of housing among people living with HIV, HCV, and STIs.** We're building on SF's Community Call to Action to address housing insecurity for PLWH by making changes to our housing system including planning to subsidize, build, incentivize rental to people with low-income, collaborate to coordinate care, support people accessing housing, utilize technology to assess housing availability, and guarantee safe, stable housing immediately upon discharge for people completing residential mental health and substance use treatment.			✓	
19	**Routinely collecting, analyzing, and publicly reporting** comprehensive information about viral hepatitis epidemiology and outcomes, particularly for HCV.			✓	
20	**Conducting an assessment of the City Clinic infrastructure to identify gaps and improve service quality.** We will conduct an infrastructure assessment and community perspectives assessment so we can enhance express services and address clinic efficiencies in our city's cutting-edge municipal STI clinic.			✓	
21	**Facilitating cluster detection and response through new partnerships and processes**. We will expand our capacity to identify and respond to outbreak clusters when they occur.				✓
22	**Rapidly identifying HIV transmission clusters using Secure HIV-TRACE, and intervening appropriately**. The HIV surveillance team will run Secure HIV-TRACE on a weekly basis to identify transmission clusters and share information with LINCS for rapid follow-up. We will also investigate, locate and link to care San Francisco cases identified by CDC as being in a multi-jurisdictional transmission cluster, and work with the California Department of Public Health as needed to identify and intervene urgently for multi-jurisdictional clusters.				✓
23	**Identifying populations experiencing increases in new diagnoses by running the CDC time-space analysis program.** On a monthly basis, we will run the time-space analysis program to identify populations with increases in new diagnoses.				✓
24	**Regularly monitoring drug-resistant strains of HIV.** Analyses of molecular surveillance data to identify drug resistant strains of HIV will be ongoing, with an annual summary of results that is disseminated to providers and others through community leaders.				✓

Key Partners

Given the broad-based nature of linkage and navigation services, SFDPH will rely on numerous partners to build a seamless system of care. We will work with key partners to complete these proposed programs, including:

- **Public, nonprofit, and private healthcare partners.** HIV, HCV, and STI tests are delivered by a broad network of public, nonprofit, and private healthcare settings in SF. The San Francisco Health Network, inclusive of both hospital (ZSFG) and ambulatory care partners is instrumental, as are community-based partners such as those who are part of the HIV-AIDS Provider Network (HAPN). In addition to these numerous existing testing and treatment partners, SFDPH will establish new partnerships with mental health and behavioral health services in SF to ensure connections to intensive case management for people with behavioral health needs and high risk of HIV, HCV, or STIs.

- **Getting to Zero.** SF's collective impact initiative to get to zero HIV deaths, zero new HIV infections, and zero HIV stigma will be a major partner to implement most strategies in this plan.

- **The HIV Community Planning Council.** This collaborative regional planning body consists of volunteers and government appointees from throughout SF, including PLWH, community members, and representatives of private and public agencies providing a wide range of HIV-related services and programs.

- **End Hep C SF.** This collective impact initiative is committed to eliminating HCV in San Francisco, and is a key partner particularly related to ending the HCV syndemic.

- **The African American Faith-based Coalition,** to build greater in-roads into B/AA communities and better meet their needs in a holistic, community-centered way.

- **San Francisco Departments.** To achieve the game-changing approaches identified above in "Key Activities and Strategies," we know that key partners will include San Francisco Departments including the Department of Homelessness and Supportive Housing and Human Services Agency; Behavioral Health Services; and Jail Health Services, as well as working closely with law enforcement (police department, sheriff's department, and the District Attorney's office). Within SFDPH, the Street Medicine team, programs serving priority populations, LINCS, and the HIV surveillance molecular surveillance team are crucial to our success.

- **Non-profit community partners.** The City relies on a mix of nonprofit community partners with deep experience and expertise in delivering HIV, HCV, and/or STI services, and those newer to those services but with deep access to the highest priority populations outlined in this plan.

- **HIV-AIDS Provider Network (HAPN).** San Francisco's HIV/AIDS Provider Network (HAPN), a coalition of community-based, non-profit agencies providing case management, mental health and substance use, food, housing, and other services will also be a vital partner.

- **External partners.** Examples of collaborations with external partners include educational institutions, pharmaceutical companies, the California HIV/STD Prevention Training Center (CAPTC), consultants, and Cepheid, which will provide materials and reagents to support our validation of their point-of-care testing platform.

San Francisco's Plan to End the Epidemics

When originally developing this plan as part of CDC PS-19-1096, we fully expected to undertake a detailed planning process, with a workplan for activities to be completed in year 1 of implementation, and years 2-5. However, the COVID-19 pandemic has increased uncertainty about the future of HIV, HCV, and STI interventions due to health and safety, financial, and logistical concerns. Because of COVID-19, it is now impossible to reasonably assign a timeline to these activities. We plan to reserve year 1 of implementation largely for further planning the determine the most effect ways to respond to the needs of people living with or at risk for HIV, HCV, and STIs while also working to prevent COVID-19 transmission, and care for those who have fallen ill. This iterative plan will have more clear definition and timelines as we all adjust to the "new normal," but in the meantime, all activities are noted as being planned in years 1-5.

Pillar 1 Activities: Diagnose

Over the last decade, San Francisco's HIV testing providers helped to normalize testing as part of regular health maintenance. These strategies proved effective; however, many places offering free and easily-accessible HIV testing still do not routinely offer HCV and STI testing, despite clients continuing to be at risk for these other diseases. Due to the overlapping risk factors for STIs, integrating HCV and STI testing across most sites will create a person-centered holistic approach to sexual health that will help in achieving the city's overarching EtE goals of getting to zero new HIV diagnosis, eliminating HCV, and reducing the number of untreated STIs. This plan supports routine opt-out HIV testing as recommended by CDC,[155] but also integrates testing for HCV and STIs.

1. Diagnose
Pillar 1 Activity 1. Provide integrated testing at more than 50 community-based or clinic-based programs in San Francisco by the end of year 1, with at least 5 types of tests (HIV, HCV, gonorrhea, chlamydia, and/or syphilis) available in a single visit, potentially also with COVID-19 testing.
Addresses: *National Strategy 1a. Expand or implement routine opt-out HIV screening in healthcare and other institutional located in high prevalence communities*   *National Strategy 1b. Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings*
Outreach   • Create **outreach models that are not one-size-fits-all,** but take into account the diversity of priority populations, developed in close coordination with **community leaders** to tailor outreach methods as needed   • Create **culturally appropriate advertising campaigns** designed by and for Latinx, Black, and trans people, not just translated campaigns for other communities   • Provide **advertising materials in languages other than Spanish**, including Brazilian Portuguese and the indigenous languages of Central America   • Advertise using **social media campaigns**, including WhatsApp, Instagram, Grindr, and House Party   • Include **linguistically appropriate sharable content** in social media campaigns and event notifications   • Create advertising that encompasses people who are members of **multiple priority populations**, for example immigrant youth and/or Black trans women   • Provide outreach specifically oriented toward Latinx **straight-identified MSM**, who may not feel connected to existing HIV, HCV, and STI-related social marketing   • Emphasize that services are available **free and low-cost, without regard to immigration status**

---

[155] CDC. Revised Recommendations for HIV Testing of Adolescents, and pregnant Women in Health-Care Settings. MMWR 2006; 55 (No. RR-14). Accessible via the web at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

1. Diagnose

- **Utilize existing assets,** such as clinic televisions, to share educational resources
- **Create a mobile unit** which comprehensively serves 1-1.5 square miles, with extended hours set up based on current locations of homeless encampments, information from the scouting unit, and known high traffic areas
- Create a **Scouting Team** that works within homeless encampments or areas where many unhoused people are living, to provide outreach, testing and referrals to other services
- Provide testing for HIV/HCV/STIs **at family events for formerly incarcerated folks**

Integrated testing encounters

- **Implement a new framework** for testing services that more closely links HIV testing, PrEP, and more frequent STI screening, along with HCV testing where indicated
- Whenever possible, testing facilities will provide clients with rapid (ideally point-of-care) HIV and HCV antibody testing, HCV RNA testing (confirmation of infection), and STI testing, including self-collected oral, rectal, and vaginal swabs for gonorrhea and chlamydia tests, and blood draws for syphilis testing
- Expand the use of **low-threshold, express, and patient-centered** testing settings
- **Implement a model that dilutes the stigma** connected with HIV/HCV/STIs **by offering more generalized services** such as COVID-19 or diabetes screenings as well as **hormone therapy** for trans people, alongside these disease-specific services
- **Provide non-healthcare services** such as legal assistance whenever possible as part of integrated testing
- In later years, expand the integrated HIV testing framework beyond SFDPH-funded community-based organizations or clinics to other health care systems serving patients from the prioritized populations
- Create a fun and engaging, **empowering testing environment** that makes clients want to return
- **Strategically empower** clients to make choices for themselves through provider training and structural changes, making the provider-client relationship more like a partnership

Expanding access

- Shift to an **"any door is the right door"** model of care, instead of services restricted by siloed funding
- Offer more **mobile testing**, conducting at least 10% of tests within 2 miles of provider headquarters
- Offer **testing at shelters, food pantries, housing sites, SROs, and other locations** that serve people impacted by poverty and/or housing instability
- Offer testing in venues frequented by people likely to have high rates of undiagnosed or untreated HCV, including **syringe access programs, drug/alcohol treatment programs, and residential facilities**
- Offer **testing in spaces specifically meant for trans women,** where they will be free from stigma from providers, staff, and other clients, and welcomed with trans-centered programming and support
- Reduce or eliminate **identification requirements** for testing in all locations
- Improve access to services for a **nocturnal work force** and others, through providing more **extended testing hours**, including late night, early morning, and weekend hours
- Pilot a **"Drop 'n' Go"** or express testing model for integrated testing, building upon local successful pilots
- Locally implement the **"TakeMeHome"** HIV/STI Testing Program to provide mailed test kits to priority populations, particularly during the COVID-19 pandemic
- Use the **Scouting Team** described above to provide some testing, **direct people to facilities for blood draws**, and providing vouchers for **extra incentives** to be obtained when they are able to prioritize attending the clinical site
- Fund **HIV and HCV screening at key pharmacies** in SF
- Provide **incentives** for testing in cash when possible, or in denominations that are easily redeemable

Results and linkages

- Deliver **face-to-face disclosure** of positive HIV, HCV, and STI test results when possible
- **Explore alternative means of results notification** for populations who have been less likely to return for results in person, including phone, internet, and other private means
- Improve rates of **RNA confirmatory testing** for people who receive positive antibody test results for HCV
- Support and advocate for progress toward mandatory **reporting of all negative HCV RNA results** from laboratories in San Francisco (and throughout California), to better assess rates of clearance and cure
- Create a mechanism for **systematic disclosure of HIV/HCV/STI test results** for people who test positive **while in jail, but are released** before notification of results
- **Link clients directly to prevention or care services**, **and/or navigate** them to SFDPH's Linkage Integration Navigation Comprehensive Services (**LINCS**) or other navigation services for clients to access, including:

1. Diagnose

- ○ Primary care, including HIV care, HCV treatment, STI treatment, and/or PrEP
- ○ Hormone therapy
- ○ Dental care
- ○ Other low barrier treatment access points (i.e. syringe services programs, mental health treatment, opiate substitution therapy, and other substance use treatment)
- Ensure **follow-up on all clients testing positive for STIs** to ensure they are adequately treated or referred for treatment
- **Partner notification** for clients testing positive for STIs through Partner Services or self-disclosure
- When referring clients for other services, **refer to specific people,** not just institutions

For us, by us

- Hire **advocates with lived experience** to encourage people to get tested and know their status, reducing stigma while improving workforce opportunities for people with less formal education and critical value and skill
- **Ensure racial/cultural/experiential equity** among testing staff, including by providing appropriate compensation to all workers, including those in frontline or "peer" positions
- Make **skill-based hiring decisions,** not just education-based
- **Reflect priority communities at all levels**, including doctors, nurses, researchers, and upper management
  - ○ **Recruit providers who have been marginalized themselves**
  - ○ **Invest in and prioritize** supporting, educating, hiring, and retaining communities of color in all levels of the healthcare delivery system

Ongoing, innovative community engagement activities

- Establish **ongoing advisory pathways** with priority communities that
  - ○ are led by the community,
  - ○ include peer leadership development, and
  - ○ meaningfully compensate community members for their time and expertise

Magnet Care/Health Access Points (HAPs)

- **Create status-neutral HAPs** for populations experiencing disparities
- Develop standards of care for ensuring consistency and **integrating HIV/HCV testing** at all HAPs
- **Hire and train** multidisciplinary teams with deep expertise and cultural competence
- **Tailor services** to the needs of the community by integrating other important services, including:
  - Mental health care
  - Substance use counseling
  - Hormone therapy
  - Hair removal
  - Food
  - Employment training
  - Life skills support
- Provide **trauma-informed care**
- Ensure **continuity of care**
- **Limit the amount** of personal information collected
- **Minimize paperwork**

Mobile and street-based services

- **Develop a "mobile services model"** for HIV/HCV/STI screening, prevention, and care, and services for PWUD that are locally tailored, integrated, harm reduction-based
- Provide **overdose prevention and low threshold access** to medication-assisted treatment (MAT) such as naltrexone and buprenorphine
- Create culturally-specific one-stop, integrated, mobile HIV/HCV/STI **Mobile Health Access Points** (M-HAPs) for B/AAs in the Bayview/Hunters Point neighborhoods
- Offer **mobile testing in neighborhoods** where many trans women live and work
- Offer **mobile or venue-based testing where people already are**, **at times that they can access them**. Consider community centers, food banks, storage lockers, laundromats, etc.
- Create a **safe space with extended hours** where people can rest and get off the street that includes integrated testing and treatment services

Communal health model

- **Move toward a community-focused approach to healthcare** in which people see themselves as promoters of well-being for their loved ones, social circles, and communities of origin

1. Diagnose

- Ensure that service providers **greet clients warmly** and welcomingly, at all levels of the organization
- Underscore **key messages** around safety from immigration during service provision, and the value of health and wellness to maintain productivity
- **Emphasize security of personal data,** and that data will not be provided to law enforcement or ICE
- Emphasize the **communal message of U=U**, in addition to the HIV prevention messaging
- **Consider cultural norms when branding messages.** For example, sex-positive branding may be offensive in conservative Latinx cultures, so other messages may be required as well
- Work with providers to encourage **self-advocacy**, particularly for Latinx clients who may be used to different systems of care and deferent relationships with clinical providers
- Ensure that providers can **answer client questions** immediately, directly, and in the client's first language
- Provide **information in languages other than Spanish,** including Portuguese and Mayan languages
- Create a **services FAQ page specifically for immigrants**, created by an immigration lawyer
- **Educate and outreach to church and religious leaders** regarding service options and the importance of sexual health and substance use-related care as a part of overall healthcare
- Provide **continuing education in relevant topics** to community members
  - Consider partnering with a local college for **credits toward a degree**
  - Consider **financial incentives**
  - **Collaborate with money transfer services** such as MoneyGram or Western Union to incentivize **educational videos in exchange for reduced transfer fees** or other benefits

Ongoing support

- Implement a **testing reminder program** using the Mobile Commons[156] platform
- **Provide additional services**, such as vaccinations for Hepatitis A & Hepatitis B, testing for TB and pregnancy, and/or offer hormone level checks, as appropriate.

Pillar 1, Activity 2. Expand the reach of HIV, HCV, and STI testing efforts through the use of peer-focused programs that hire and support people with lived experience in the priority population(s).

Addresses:
National Strategy 1a. Expand or implement routine opt-out HIV screening in healthcare and other institutional located in high prevalence communities
National Strategy 1b. Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings

Recruitment

- Recruit and remunerate **persons with lived experience** to work within social networks of priority populations to promote proactive HIV/HCV/STI prevention, testing, and treatment strategies
- Recruit and remunerate more **young B/AA women and men** for SLAY (Sistas Leadership for African American Youth) to participate in developing strategies and sexual health messaging for that community
- Develop *promotora*-style peer-based programs for Latinx persons, recruiting and remunerating workers who **build ongoing relationships** and prioritize **individualized** interactions
  - Promote messaging around **free, confidential tools** to maintain health and lifestyle
  - **Frame messaging in terms of wellness/strength**, not sickness/disease
- Recruit and remunerate trans women to lead programs by and for trans women, incorporating the **peer-to-peer Sisterhood** model in programs, with a particular focus on meeting the needs and confidentiality concerns of trans women who are sex workers and/or fear interpersonal violence as a result of their involvement
- Recruit and remunerate persons with lived experience of substance use and/or homelessness to act as **HIV/HCV/STI counselors and peer navigators** for PWUD, particularly those who are unhoused or experiencing housing instability
- Choose workers based on **holistic knowledge and capacity to resolve**, not just language competence or other community linkage
- Create **testimonials for outreach events** to increase community buy-in and engagement

Training

- **Support organizations** in providing agency-specific training to workers from the community

---

[156] Mobile Commons SMS service information available at: https://nationbuilder.com/mobilecommons

1. Diagnose

- Provide formal training around HIV, STIs, and HCV for *all* community leaders
- Provide training relating to approaches to **treatment, outreach, and engagement**
- Provide **training relating to community concerns**, such as law enforcement/ICE and data security, or drug interactions with hormone therapy
- Provide **training related to partner notification and contact tracing** for trans women and sex workers
- Ensure strict adherence to **confidentiality policies** among tightly-knit communities

Support

- Provide **long-term, well-paying jobs** for workers hired for their lived experience
- Provide **ongoing clinical supervision and social support** for peer counselors and navigators
- Create workforce development that **supports employee retention**, not just recruitment
- Create a **mechanism for linkage** to peer navigators for communities that have barriers to staying engaged in care
- **Support workers** by a trauma-informed workplace and access to therapy

Improve opportunities for community leadership

- Explore best practices for **developing a Community Leadership Institute** to fully launch in year 2, to provide tangible community certification or linkage to employment
  - Consider **intention, roles, and training**
  - Strive for **flexible work hours** to meet the needs of individuals with competing needs
  - Consider **transit reimbursement**
  - Include **mentorship/apprenticeship options**
  - Include opportunities for **work outside a person's immediate community**
  - Provide a focus on **empowerment and building self-efficacy**

Pillar 1, Activity 3: Expand or implement routine opt-out HIV screening in healthcare and other institutional settings located in high prevalence communities, alongside HCV and STI screening where indicated.

Addresses:
National Strategy 1a. Expand or implement routine opt-out HIV screening in healthcare and other institutional located in high prevalence communities

Clinical Champions

- In year 1, fund a ZSFG Clinical Champion to work to **increase HIV/HCV/STI screening,** PrEP awareness and prescribing, and HCV treatment prescribing
- In later years, launch Clinical Champions programs at all major hospitals in SF

Public Health Detailing

- Conduct **city-wide academic detailing for HIV, HCV, and STI screening in hospital settings**, PrEP, HCV treatment, naloxone co-prescribing, and cultural competence with people experiencing homelessness
- **Normalize HIV/HCV/STI testing** by offering it as part of routine health checks for everyone instead of just for higher-risk populations
- **Develop toolkits** for roll out of point-of-care syphilis testing

Pillar 1, Activity 4: Increase rates of at least yearly re-screening of persons at elevated risk for HIV per CDC testing guidelines, in healthcare and non-healthcare settings.

Addresses:
National Strategy 1c. Increase at least yearly re-screening of persons at elevated risk for HIV per CDC testing guidelines, in healthcare and non-healthcare settings.

Public Health Detailing and Clinical Champions

- Conduct city-wide **academic detailing, clinical education, consultation, and continuous QI efforts** to increase rates of HIV re-screening

Outreach and Engagement

- **Expand outreach and engagement efforts** through HAPs and M-HAPs, as well as peer-focused programs that hire and support people with lived experience in the priority populations
- **Dilute the stigma** connected with HIV/HCV/STIs **by offering more generalized services** such as COVID-19

1. Diagnose

or diabetes screenings, or hormone therapy
- **Create infographic educational materials** for patients in clinical settings to increase community advocacy and engagement in annual re-screening
- Create other **creative ways of distributing information** to change social norms and increase re-testing rates**,** such as bracelets or branded items
- Provide **trauma-informed and culturally capable risk assessment counseling** to develop strategies for managing stigma that prevents continued engagement in testing services
- Utilize **peer-based, *promotora*-style** programs tailored to the needs of priority communities, as detailed further in Pillar 1, Strategy 2.
- Consider providing a **record of ongoing testing** for transmissible disease to reduce criminal charges for sex-worker crimes

Pillar 2 Activities: Treat

Effective treatment for HIV, HCV, and STIs goes far beyond what takes place during a single clinical encounter. San Francisco's approach to Pillar 2 weaves together linkage and navigation to ensure access to and retention in care; the delivery of state of the art treatment for HIV, HCV, and/or STIs; the delivery of treatment services for significant comorbidities, most notably mental health and substance use; unrestricted treatment access; addressing specific concerns, such as drug interactions with hormone therapy; re-engagement for people who have been lost to care; and the provision of housing support as a crucial element to care.

2. Treat

Pillar 2, Activity 1. Provide comprehensive linkage and navigation to HIV, HCV, and STI services, including removing restrictions to care provision related to funding source or other bureaucratic requirements.

Addresses:
National Strategy 2a. Ensure rapid linkage to HIV medical care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV
National Strategy 2b. Support re-engagement and retention in HIV medical care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Programs.

Structural changes
- Expand SF's LINCS (Linkage, Integration, Navigation and Comprehensive Services) to include **linkage and navigation support for HCV and STIs**, and build connections with navigators in community-based organizations to ensure coordinated care and equitable, streamlined service for all people
- Begin to **receive reports of negative HCV RNA test results** in San Francisco, so that epidemiologists in in the Viral Hepatitis Surveillance unit can identify people living with HCV who have not yet been treated, and work with community-based or health systems providers to offer them lifesaving treatment
- Provide HCV treatment at all **SFDPH-run primary care and methadone** programs
- Expand HCV treatment options in **non-clinical sites**, including **SROs, shelters, and navigation centers**
- **Invest in and prioritize** supporting, educating, hiring, and retaining **communities of color and people with other relevant lived experience** in all levels of the healthcare delivery system
- **Increase** the number of full-time **clinicians** available in three of San Francisco's busiest **city-run health clinics**

2. Treat

- **Share data** between ARCHES-HIV Surveillance (SFDPH) and LINCS to ensure that all persons newly diagnosed with HIV or HCV in SF receive **partner services and linkage to care** assistance at time of diagnosis
  - **Prioritize vulnerable populations** such as people experiencing homelessness, unstable housing, or incarceration
  - **Hire at least one epidemiologist** to manage, analyze and evaluate all data related to HIV and HCV care navigation and outcomes
  - Implement strategies to **improve completeness and timeliness of case and lab reporting**, and data analysis and evaluation of care
  - Develop policies and procedures for **sharing of STI data and information** between ARCHES and Community Health Equity and Promotion (CHEP) within SFDPH to **improve data-driven decision-making** related to STI incidence, service utilization, and other key STI indicators
- Staff in community-based organizations funded by SFDPH will all be cross-trained on HIV/HCV/STIs
- Further **develop the STI workforce**, both within and outside of SFDPH, so that SF is fully equipped to provide comprehensive, sex-positive STI care, prevention, and education services, and incorporate STI education and training into conferences, summits, and trainings related to HIV or HCV in the city
- Use an acuity scale to **determine level of care in services** to support HIV, HCV, and STI treatment
- **Allow the blending of** HIV prevention and care **funding streams** to allow a single staff person to provide a full array of status-neutral HIV services
- Use express visits to **provide access to rapid ART initiation and express STI treatment** to patients testing positive using home test kits or referred through the "Drop n' Go" program described in Pillar 1, Activity 1
- Examine sending **electronic prescriptions** to a pharmacy that will deliver medications to a patient at the location of their choice, to decrease logistical hurdles
- Consider creation of a **limited-caseload comprehensive case manager** position that will work closely with a small number of clients living with HIV or HCV across all specialties
  - In year 1, support the limited-caseload case manager to create a **systems review report** of critical gaps in HIV or HCV care and linkage, to enable systems change

Deliver linkage and navigation to new communities

- Provide culturally humble, non-judgmental, stigma-free, and sex-positive linkage and navigation services for people living with HIV and HCV, as well as **people living with an STI without access to medical care** so they can obtain treatment
- Explore opportunities to expand this approach to include **linkage to housing and behavioral health** services
- Explore to use of LINCS-provided Tier 2/intensive **field-based case management**-type support and **street-based interventions**
- **Expand the use of peer navigators** in clinics that serve people living with HIV and HCV, emphasizing peer-based models of support that improve responsiveness to the unique needs of priority communities
- Expand funding for the **End Hep C SF Community Navigator** program into new organizations and settings, including SROs and other non-traditional venues where people are still living with HCV
- Provide linkage services during **extended hours**, particularly for people part of the **nocturnal workforce**
- **Provide** blended, status-neutral, **whole person care** services to people experiencing homelessness, alongside and as part of HIV and HCV treatment services
- Consider the creation of a **Health Care Assistant** position, specifically designed for helping PWUD manage HIV, HCV, or substance use treatment appointments, obtain mental health care, etc.
- **Support** the SFDPH Street Medicine and Shelter Health program **(Street Medicine)** to:
  - Provide medical and behavioral health services
  - Address trans-specific needs such as hormone therapy
  - Provide street-based telehealth buprenorphine services
  - Address basic needs such as lack of food, shelter and clothing
- Link people experiencing homelessness who are not virally suppressed **to ZSFG's POP-UP clinic** (see Pillar 3, Activity 2)
- Develop strategies to ensure Latinx clients are **oriented to the San Francisco health system**
- **Emphasize security of personal health data,** and that data will not be provided to law enforcement or ICE
- Provide **information about HIV, HCV, and STI treatment in languages other than Spanish,** including Portuguese and Mayan languages

2. Treat

Mobile outreach and activities of Centers of Excellence (CoE)

- Expand on the CoE model to **provide more mobile outreach and linkage to care** for priority populations.
- Adopt **CoE-developed services and program culture** adapted to the needs of specific communities, including the needs of people who are part of a nocturnal workforce, and those with specific health concerns such as drug interactions with hormone therapy or street drugs

Expand services at City Clinic

- Provide **drop-in access** to ART re-initiation, HIV testing, PrEP, and HIV primary care services at City Clinic, including during **night clinic** hours
- **Expand integrated STI/HIV services**, including integration of point-of-care HIV viral load testing to rapidly identify PLWH who are not virally suppressed
- Offer **partner services and counseling** to PLWH who are not virally suppressed by **an on-site navigator** to re-initiate ART if not in care, and offer soft handoff to a LINCS navigator
- For PLWH who are diagnosed with gonorrhea or syphilis at City Clinic and are not virally suppressed, **pilot offering partner services** to identify partners who do not know their HIV status and might benefit from PrEP or might need to be re-linked to care

Offer robust training for service providers to enhance treatment services

- Create a case management curriculum that builds on existing knowledge to ensure brief thoughtful **assessments** are performed regularly for people living with HIV and HCV, building **meaningful rapport** and providing **trauma-informed care** while **guiding clients through the healthcare system,** which may differ from the systems most familiar to them
- Provide **transgender sensitivity training** to *all* employees, especially in agencies that serve substantial numbers of trans clients/patients
- Encourage **provider education** around working with PWUD, especially how to work with those who are deemed problematic, noncompliant, service resistant, combative, or "frequent flyers"
- Provide **drug education for providers** who prescribe pain killers, to improve knowledge of drug interactions with illicit substances, ensure patients receive adequate pain care, and make it safer for patients to be honest about substance use when seeking care

Pilot innovations in HIV treatment

- **Dedicate resources to evaluating** long-term ART (new) both separately and, when clinically indicated, in combination with long-term psychiatric medications
- Following the validation results of the point-of-care HIV VL assay (see Pillar 3, Activity 10), **determine how point-of-care or lab-based HIV viral load testing can be used for**:
  - o **Targeted testing** of patients with suspected acute HIV infection, to rapidly link to care
  - o **Targeted screening** of PLWH to determine who is not virally suppressed and may need additional support with adherence or re-engagement in HIV care

Pillar 2, Activity 2. Deliver same-day diagnosis and treatment for HIV, HCV, and STIs.

Addresses:
National Strategy 2a. Ensure rapid linkage to HIV medical care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV
National Strategy 1b. Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings

Same day diagnosis and treatment of HIV

- Identify, track, support, and promote collaborative **activities to increase knowledge and utilization of the** San Francisco Rapid ART Program Initiative for HIV Diagnoses **(RAPID) program**, including supporting efforts to expand funding for that program where needed
- Ensure **culturally and linguistically inclusive** branding and outreach for RAPID
- Ensure sufficient **system capacity** to provide same day HIV treatment in primary care clinics throughout the San Francisco Health Network, improving upon the current "timely access" standards (10 business days from diagnosis to treatment)
- Build more responsive systems for **Releases of Information** to allow for better follow-up after someone receives treatment the same day as their diagnosis, but from a different location

Same day diagnosis and treatment for HCV

2. Treat

- **Develop partnerships** with educational institutions, insurance companies, and pharmaceutical companies **to remove barriers** related to HCV medication access, including cost and prior authorizations
- Support and initiative for **rapid HCV treatment starts** at places that serve PWID, such as (but not limited to) syringe access services, mobile testing sites, and health fairs
- Collaborate with the SF HIV **Frontline Organizing Group (FOG)** for improved awareness about and strategies for rapid access to HCV treatment
- Increase **public knowledge** of patient assistance programs for HCV medications

Same day diagnosis and treatment for STIs

- Expand STI-specific partnerships related to programs for presumptive STI treatment and "partner packs"
- Expand use of **rapid syphilis testing** where appropriate to enable same-day treatment

Pillar 2, Activity 3. Support re-engagement and retention in HIV and HCV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS programs.

Addresses:
National Strategy 2b. Support re-engagement and retention in HIV medical care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Programs.

Expanded re-engagement and retention model

- Develop an **expanded re-engagement and retention model for clients** who need long-term or ongoing support with behavioral health, substance use, and other needs
  - Include **linkage and navigation support** for HIV/HCV/STIs, housing, and behavioral health
  - Emphasize **peer-based models** of support
  - Provide service delivery and programming during **extended hours**
  - Expand options for **Intensive Case Management** for those with high acuity
  - Integrate **mobile and street-based linkage and navigation** services, especially for trans women and people experiencing homelessness.
- Provide linkage and retention support within **community centered services** that focus on providing welcoming, caring environments for trans people, PWUD, and/or people who are unhoused, including alongside provision of food, cell phone charging, WiFi access, clothing, bedding, harm reduction, and hygiene supplies
- Help clients stabilize their lives through employing **harm reduction strategies** and accessing other HIV/HCV/STI prevention interventions while receiving treatment
- Launch **pilot program at Gender Health SF** with a new, full-time Patient Navigator who will work with people who are seeking sex reassignment surgery
- Explore deepening the range of services currently offered to **develop** a robust and **tiered system** that provides the appropriate level of support to each client that can be implemented in years 2-5
- Ensure **continuity of care during incarceration**, including HIV, HCV, and STI care, as well as trans healthcare

Medication access and storage

- Provide **lockers** at shelters, navigation centers, SROs, and drop-in centers **to hold prescribed medications**
- Offer combination locks for **security**
- Allow clients to keep lockers for at least **six months** before emptying or giving to another client

Transportation

- Expand **transportation options** for people seeking treatment for HIV, HCV, or STIs
  - **Consider a shuttle** that travels from shelters, navigation centers, etc. to clinics with a set schedule
  - Assist clients in obtaining **monthly MUNI passes** that will enable ongoing medical care and treatment

Post-incarceration services

- Hire a full-time, **status-neutral Navigator** to provide basic case management, referral, and linkage to HIV, HCV, or STI treatment and other social services, for people exiting jail
- **Coordinate linkage to ongoing HIV and HCV care** as part of post-release services
- **Meet clients** directly **upon their release from jail** or as soon as possible after release, including **navigation services for people who are released at night,** when regular services and support systems are unavailable
- Engage with clients for at least 90 days following release

2. Treat

Pillar 2, Activity 4: Substantially deepen the provision of mental health care for people living with HIV and HCV, and people at highest risk for HIV, HCV, and/or STIs

Addresses:
National Strategy 2a. Ensure rapid linkage to HIV medical care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV
National Strategy 2b. Support re-engagement and retention in HIV medical care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Programs.

Accelerating linkage to treatment
- **Reduce extended wait times** for behavioral health services and psychiatric treatment for PLWH, as well as those who are at high risk for HIV or with an unknown HIV status who are not active in primary care services
- **Explore employing Behaviorists** as part of client care teams for people living with HIV and HCV, to provide short-term assessment and counseling as a bridge to longer-term mental health engagement
- Establish intentional systems for linking patients to **culturally and linguistically-appropriate therapists**

Service integration
- Increase the availability of **mental health services** at primary care and testing sites.
- Explore opportunities to bring HIV, HCV, and STI **testing into mental health treatment settings**.
- Ensure that the staff at trans-serving agencies are able to **address** the complex mental health needs **and requests of trans women**
- Provide culturally competent care that addresses **trans issues** and the **intersection of race, socioeconomic status, and immigration status**
- Ensure that mental health services (including psychiatric telehealth support) are integrated with HIV care for all PLWH through their **HIV client care team**

Expanded access
- **Expand San Francisco's Behavioral Health Access Center (BHAC)** to operate 24 hours a day, 7 days a week, 365 days a year
- **Expand** the number of dedicated professionals delivering **Intensive Case Management** (ICM) to people living with HIV or HCV who also have mental health concerns
- Explore expanding the availability of **subsidized, long-term mental health services** for PLWH, particularly where annual insurance coverage of mental health counseling services has expired
- Pilot approaches to expanding access to high-quality, culturally appropriate psychiatric services through **psychiatric telehealth** models for real-time and clinical consultant services
- Seek new ways to **expand mobile access** programming to the delivery of mental health services, and **improve crisis services using mobile response teams**

Innovations in co-dispensing psychiatric and HIV or HCV medication
- Evaluate **long-term ART** (new) both separately and, when clinically indicated, **in combination with** long-term **psychiatric medications**
- **Expand HCV treatment capacity** at sites specializing in mental health care, especially those with systems to provide directly-observed therapy for psychiatric medications

Pillar 2, Activity 5: Expand opportunities for on-demand, low-threshold substance use treatment access that adheres to harm reduction philosophies and allows for non-traditional engagement strategies regardless of HIV, HCV, or STI status.

Addresses:
National Strategy 2b. Support re-engagement and retention in HIV medical care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Programs.

Improve low-threshold access to substance use treatment and contingency management programs
- **Streamline** administrative workflows and inter-agency processes to optimize placement of clients (both those in the community and those exiting jail) in existing program spaces
  - Expanding the number of staff performing intake assessments, assessment hours, and locations (e.g. in custody settings, off-hours, etc.) to allow for immediate connections to services
  - Invest in resources to transport more clients to treatment
  - Leverage city funds to supplement Drug Medi-Cal reimbursement shortfalls

2. Treat

- o   Improve coordination between agencies for discharge planning and reentry service
- o   Explore ways to honor client consent for information sharing while facilitating communication and collaboration between providers to improve client/patient care
- **Expand the Behavioral Health Access Center** (BHAC) to 24/7/365 operation, including a 24-hour call line and access to pharmacy
- Make **methadone more accessible**
  - o   Consider **decreasing identification** requirements
  - o   Increase **available spaces** for new patients at clinics
  - o   **Simplify intake**
- Improve access to addiction medications **for people who use alcohol**
- Explore use of methylphenidate, dextroamphetamine, mirtazapine, and other treatment or substitution options to **medically assist people with methamphetamine use disorder** to manage or reduce their use
- Increase access to **on-demand substance use services**
- Increase the availability of **detox centers**
- Provide **significant rewards** to people who test negative for substances after having tested positive
- Consider having a **waiting facility** for people wanting to get into treatment, similar to a sobering center
- **Provide vouchers** for hotel rooms, food, clothing and other necessities **for those waiting for treatment**
- Provide **incentives** for people who undergo substance testing

Fill service gaps for key populations

- **Bring together partners** with expertise in specific service approaches and those who have deep understanding of the needs of key populations
- Increase the availability of **outpatient treatment programs for people who use methamphetamine** in addition to gay men
- Ensure services are **culturally and linguistically appropriate**, particularly for communities that may be at greater risk of marginalization or injury.
  - o   Provide staff training on **cultural sensitivity and humility**
  - o   Ensure all materials are translated into threshold languages
  - o   Modify physical spaces to **facilitate privacy and social needs** wherever possible
  - o   Enhance the workplace with hiring practices to recruit, support, and retain people with lived experience of substance use
  - o   **Provide pay differentials** for multi-lingual staff
- Support programs that distribute crack pipes to improve drug user health and prevent HCV transmission
- Advocate with elected officials and politicians (including probation department, SFPD, Sheriff's Department, Courts, and the reentry council) to **adopt a new approach to drug use as a health issue**
  - o   Provide ongoing education and reinforcement in this approach for the SFPD, and ensure accountability
- **Look for alternatives to incarceration for PWUD**, as well as alternate sentencing strategies, to reduce time in custody and away from substance use treatment and harm reduction supports
  - o   **Divert** eligible individuals to community-based health and social services that focus on the person's medical and behavioral health, employment, and stable housing
  - o   Increase the use of **Collaborative Courts** and court-mandated treatment to address mental health, substance use disorder, or other social service needs
  - o   **Increase availability of harm reduction/non-abstinence programs** that Collaborative Courts can refer eligible clients to as needed
  - o   Provide training for criminal justice partners on how to engage clients in ways that **reduce trauma and improve treatment engagement**

Address stigma

- Continue to **address and manage challenges with the media and public perception**, including developing talking points related to the values/benefits of syringe access and harm reduction
- Provide education on **community values and community culture** to 'new neighbors" (neighborhood associations, local tech industries Community Benefit District boards, arts and social groups), using messages that normalize harm reduction programs and policies, community organizing strategies, and PWUD as spokespersons to humanize and reduce stigma

2. Treat

Telebupe

- **Pilot initiating buprenorphine using a telemedicine vendor**, to allow for prescription and pharmacy pickup of buprenorphine even when a certified provider is not on-site (including during street outreach or late night/weekend service hours)

Strengthen collaboration and enhancing systems among city agencies and service providers

- Improve coordination of intake and eligibility of patients with a **standardized assessment**
- **Share appropriate data** across treatment and non-treatment agencies to enhance care coordination
- Educate HIV/HCV/STI providers about the full landscape of behavioral health service options
- Establish **warm hand-offs** between city services, levels of care, and behavioral health crisis teams
- Develop a set of standards for agencies to **routinely and actively gather client input** on program design and service delivery, beyond existing annual client experience surveys

Pillar 2, Activity 6: Greatly strengthen the connection between HIV/HCV/STI care and housing-related services.

Addresses:
National Strategy 2b. *Support re-engagement and retention in HIV medical care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Programs.*

Prevent homelessness among people living with HIV, HCV, and syphilis

- **Develop** standard **citywide systems for screening for risk of homelessness** (especially among HIV and HCV medical providers and community-based organizations serving priority populations)
  - **Screen and intervene** with those at risk of losing housing, at each HIV, HCV, and/or STI-related care appointment
  - **Develop and promote standardized questions** to appropriately screen for risk of becoming homeless
  - **Develop protocols** for when, where, how, and how frequently this screening should be conducted
- **Engage the HIV Housing Workgroup** hosted by the Mayor's Office for Housing and Community Development (MOHCD) as a formalized mechanism for decision making and feedback
- Develop t**rans-specific housing options** and supports tailored to the trans community
- Provide linkage to **HOPWA-funded PLUS housing** when appropriate for PLWH
- Work with various partners to develop **strategies to ensure** that people not legally able to return to their federally-subsidized former housing units after leaving hospitals, rehabilitation centers, and substance use treatment centers are able to immediately **access guaranteed stable shelter, with a pipeline to permanent housing**
  - Consider a **separate waitlist** from the current PLUS waitlist to create a pathway to housing for PLWH exiting medical, mental health, or substance use treatment
- Provide a **direct and seamless transition** to stable shelter for those exiting institutional living who do not have a home to go back to
- Utilize an **acuity scale assessment** when tailoring and prioritizing linkages to housing resources
- Fund a novel **HIV/HCV/STI housing program with Stabilization Rooms and support team** for people experiencing homelessness who are living with HIV, using PrEP, completing 8-week HCV treatment, who are pregnant women with syphilis, and/or need acute care
  - Secure access for 5 rooms in SROs in year 1, growing to 10+ rooms in subsequent years
  - Prioritize those who are transitioning from hospitalization or incarceration, as well as to medically complex and fragile clients.
- Expand and **enhance the skills and expertise of** case management, peer support, and other **staff** in relation to housing placement and referrals
- Expand **staff providing Intensive Case Management (ICM)** to support better mental health outcomes, linkage to medical care, and maintenance of treatment for people living with HIV and HCV who are unhoused or experiencing housing instability
- Explore pathways for staff at community-based organizations to **access and directly link clients to shelter beds**, built on a model similar to www.findtreatmentsf.org

Testing and treatment in shelters and supportive housing

- Support the HCV SRO micro-elimination project of End Hep C SF

2. Treat

- o Provide **nursing support and capacity-building** to improve linkage to treatment and adherence support for residents of SROs who are living with HCV
- o **Locate, train, and support community navigators** who also live in those SROs, to work with hotel nursing staff to support other residents to engage in HCV testing and treatment.
  - ▪ Hold panel discussions featuring End Hep C SF community members taking place in the hotel, adjacent to other community forums or activities
- o After the pilot project concludes, expand the program to include other SROs, other types of housing such as residential substance abuse treatment facilities or "step-down" transitional housing, and with a focus on HIV and STI diagnosis and treatment, not just HCV

Enhance housing support for Ryan White clients

- Assess, prioritize, initiate and promote effective **HIV housing support activities** within Ryan White programs
- Increase the annual cap on Ryan White **Emergency Financial Assistance**
- **Increase maximum length of stay** in the city's HIV Housing Stabilization Program

Adjust coordinated entry

- **Adjust the Coordinated Entry system** to make "priority status" a more effective measure of need, and reduce requirements to reapply in the future simply because housing stock is not currently available
- **Make more inclusive** for people living with or at high risk for HIV, HCV, or STIs such as congenital syphilis
- Ensure greater use of the Vulnerability Assessment Tool (VAT)
- Ensure that unhoused individuals in residential treatment are assessed through Coordinated Entry for **housing placement before exiting treatment**

Pillar 3 Activities: Prevent

San Francisco's integrated approach to HIV, HCV, and STIs requires a sophisticated, multi-layered strategy for prevention. For HIV alone, state of the art prevention has evolved dramatically in the last 20 years, integrating new practices related treatment as prevention, pre-exposure prophylaxis, and syringe access, among others. PrEP use in SF is increasing, with 16,300-22,000 MSM using PrEP in 2017[157] and 37-45% of HIV negative MSM on PrEP in 2019. However, PrEP use among B/AAs is lowest among all racial/ethnic groups and the rate of uptake in past years is the slowest.[158] In addition, Trans women are much less likely to be aware of PrEP than MSM, and display disparities along the entire PrEP continuum.[159] In order to realize the potential benefit of PrEP, SFDPH proposes a sophisticated, multi-layered strategy for prevention. This integrated approach will address disparities, self-perceived risk, mistrust, out of pocket costs, and access. Efforts to prevent HCV and STIs have followed suit and require an understanding of the multiple risk factors—behavioral, structural, cultural, and beyond—that inform any one person's risk for transmission.

---

[157] Buchbinder S, Cohen S, Hecht J, Brosnan H, Hsu L, Koh R, Raymond HF, Liu AY, Scott H, Bacon O, Packer T, Philip S, Havlir D, Scheer S. Getting to Zero New Diagnoses in San Francisco: The Potential Role of PrEP. Oral presentation, CROI, 2017.

[158] Liu AY, Coleman K, Walker N, Vittinghoff E, Turner C, Vinson J, Quiñonez C, Gardner E, Raymond HF, Buchbinder S, Lightfoot M, Scheer S, Arayasirikul S, Wilson EC. Assessing the PrEP Continuum in the San Francisco Bay Area: The Quickie Mobile Survey. Poster presentation, CROI, 2019.

[159] Wilson EC, Turner CM, Arayasirikul S, et al. Disparities in the PrEP continuum for trans women compared to MSM in San Francisco, California: results from population-based cross-sectional behavioural surveillance studies. Journal of the International AIDS Society. 2020;23(S3):e25539.

3. Prevent

Pillar 3, Activity 1. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP.

Addresses:
National Strategy 3a. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP

Locally-driven peer networks and groups
- Support B/AA and Latino young men to **develop locally-driven peer networks and groups** to provide a community-led safe space to discuss PrEP within their communities
- Hire or appoint **Youth Sexual Health Ambassadors** who can provide B/AA and Latinx youth with sexual and drug use health education
- **Work closely with youth** to coordinate youth-specific HIV/HCV/STI services
- **Obtain and use incentives for PrEP** as best determined by the communities

PrEP Navigators Group
- Re-institute the citywide PrEP Navigators Group
- Ensure that all PrEP navigators in SF are up to date with the **latest information on PrEP access**
- Provide a **facilitated space** to share best practices, trends, and challenges
- Provide **ongoing training** on the complex skills necessary to support patients on PrEP
- Help inform the implementation of the proposed EtE PrEP activities and development of tools

Reduce barriers to PrEP access
- Consider **telehealth assessments** for PrEP initiation
- Identify a ZSFG-based inpatient testing/PrEP champion to **scale-up clinical PrEP** services and in-patient PrEP initiation rates
- Implement a **warm hand-off system** for those leaving jail to be fast-tracked for PrEP services
- Use a "data to PrEP" to focus **enhanced outreach** on those who may be ideal candidates for PrEP
- Provide **intensified retention support** to those most likely to discontinue PrEP care
- Provide PrEP initiation and support services during extended hours, for people part of a **nocturnal workforce**

Develop a regional PrEP approach (see Theory of Change graphic at right)
- **Work with Alameda County Public Health Department** to address PrEP disparities, particularly among B/AA, with a regional approach that includes:
  - Providing coordinated, diverse, **cross-jurisdictional interventions** to support PrEP uptake in SF and Alameda Counties

Bridging the gaps through holistic cross-jurisdictional interventions to support PrEP uptake in San Francisco and Alameda Counties

Widespread and Equitable PrEP Access

Truth & Justice Reconciliation · Social Marketing · Institutional Supports · Provider Training

ALAMEDA COUNTY

SAN FRANCISCO

An initiative to undo historical trauma, especially in the Black/African American Community, will build trust around PrEP.

A social marketing campaign on BART and Muni will promote PrEP awareness and connect viewers to PrEP-related resources.

Institutional support, such as supporting same-day PrEP and LEAN training in clinical settings, will reduce logistical PrEP barriers.

Training for service providers will build capacity and cultural competency for providers to offer PrEP to clients of diverse backgrounds.

3. Prevent

- o A **Truth and Justice Reconciliation** initiative to undo historical trauma especially in the B/AA community, and address structural racism, medical mistrust (including PrEP-related mistrust), and stigma
- o **Institutional Support** such as supporting same-day PrEP and LEAN training at clinics to reduce logistical PrEP barriers
- o **Provider training** to build capacity and cultural competency for providers to offer PrEP to clients of diverse backgrounds
- o Ensuring that providers can **answer client questions** immediately, directly, and in the client's first language
- o Developing a regional but locally-tailored **social marketing campaign** that will be placed on municipal and cross-bay transportation services to promote PrEP and link viewers to PrEP-related resources, with goals to address HIV- and PrEP-related stigma, promote overall **sexual health,** and ensure that immigrants know they can get **services without information being shared with ICE**

Pillar 3, Activity 2. Improve PrEP provision to people of color, PWUD, trans women, and people who are unhoused.

Addresses:
National Strategy 3a. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP

Provide mobile PrEP to better reach key populations

- Integrate PrEP into existing mobile services, or establish new mobile services specifically to educate and initiate people on PrEP
- With **community partners,** develop **culturally responsive and appropriately structured approaches** to best reach the communities of interest in ways that are respectful, discreet, and supportive
- Solicit **patient input** to validate programs that are developed

Expand Street Medicine services

- **Support** the SFDPH Street Medicine and Shelter Health program **(Street Medicine)** to offer PrEP to people experiencing homelessness, including B/AA, Latinx, and trans people and PWUD, while:
  - o Providing **medical and behavioral health** services
  - o Addressing **basic needs** such as lack of food, shelter and clothing
  - o **Address trans-specific needs** such as hormone therapy
  - o Addressing **immigration and other legal needs**
  - o Addressing **COVID-19** related housing and health care issues

Expand the ZSFG POP-UP clinic

- **Expand the POP-UP clinic** at the Positive Health Program on Ward 86 at ZSFG by hiring a **social worker** specifically to work with people experiencing homelessness who are on PrEP, while providing:
  - o Open-access, incentivized, comprehensive, relationship-centered care
  - o Drop-in to receive non-urgent primary care as well as wrap-around supportive services.
  - o Directly-observed therapy and medication pick-ups
  - o Behavioral health services
  - o Food, clothing, and hygiene kits
  - o Referral to social services (e.g. vocational training, financial management, legal services, transportation)

Improve provider knowledge of PrEP

- Build provider trainings about PrEP to fill gaps in knowledge, learning from others who have already developed resources
- Expand the SFDPH STI **public health detailing program** to increase STI screening and linkage to PrEP in emergency departments, Jail Health, and other programs serving people experiencing homelessness
- Examine **systems-levels approaches** for large systems like UCSF, such as:
  - o Building prompts through the electronic medical record (**EMR)**
  - o Training to improve cultural responsiveness and appropriateness of PrEP initiatives
  - o Raise awareness of "Ready, Set, PrEP" and "PrEP 2-1-1" approach

Improve public knowledge of PrEP

- Ensure **racial and gender inclusivity** to reinforce the message that PrEP is not just for (white, cis, gay) men

3. Prevent

- Create **educational materials** tailored to the needs of underserved communities
- Emphasize awareness of all **payment/coverage options** to maintain PrEP use, especially to address breaks in employment or insurance coverage
- Support efforts to raise awareness of **PrEP 2-1-1**
- Provide outreach to patients who previously declined daily PrEP at City Clinic or who stopped daily PrEP to **educate them about and offer them 2-1-1 PrEP**
- **Include additional information on HIV prevention** on the City Clinic website and other relevant websites (e.g., up-to-date information on 2-1-1 PrEP, "Ready, Set, PrEP," FAQs, and locators for PrEP providers, STD clinics, and sexual health clinics)
- Work with Jail Health's HIV-Integrated Services to **increase PrEP education and counseling for inmates**
- **Work with the Mexican Consulate** to ensure that their Health Window Project provides useful information and linkage to PrEP services for Mexicans in San Francisco

Pillar 3, Activity 3. Expand PrEP 2-1-1.

Addresses:
National Strategy 3a. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP

Expand PrEP 2-1-1 efforts
- Build upon successful efforts to promote PrEP 2-1-1 regimens among gay men and other MSM in San Francisco, and **develop mechanisms to promote PrEP 2-1-1 among communities where PrEP uptake has progressed more slowly**, including people of color, trans women, PWUD, and people experiencing homelessness
  - Partner with researchers to determine the most effective methods for promoting PrEP 2-1-1 for use in communities where it has thus far not been promoted
  - Work with community partners to develop educational messaging appropriate for new communities

Pillar 3, Activity 4. Better utilize technology to communicate and engage with people in new ways regarding HIV, HCV, and STIs.

Develop a unified messaging and community strategy around STIs
- Develop a **joint communication strategy** between SFDPH, external healthcare providers, and community-based organizations, regarding STI prevention, services, and care
  - Work to determine what messages and communication strategies are most effective with communities with greatest disparities
  - Work with community partners to **deliver unified messages** to the provider community and consumers

Harness technology within SFDPH
- Create **partnerships in the tech industry** to promote, develop, and better utilize **social and health/wellness apps** across the city
- Hire a small professional **social media/marketing team** within SFDPH to manage HIV, HCV, STI, and other public health communications

Pillar 3, Activity 5. Establish a Community STI Task Force.

Hold community conversations about STIs in San Francisco
- Collaborate with community members and people affected by STIs to **better understand social and environmental factors** that influence prevention of STIs and access to STI services and care
  - Conduct focus groups or other information gathering activities with community members
- In year 1, establish a short-term Task Force to hold **community-led conversations about San Francisco's values and goals around STI prevention and care**, and determine realistic solutions to address concerns
- In subsequent years, re-establish **community advisory boards (CABs)** for STI work, and/or expand the scope of existing CABS for this purpose
  - Ensure that the goals of the CAB(s) are clearly defined
  - Incorporate STI work into pre-existing CABS that are currently focusing on other topics and have interest in expanding the work that they do

3. Prevent

- **Integrate STI-specific topics into the HCPC**, to expand their contribution to discussions and decisions on STI/HIV integration activities citywide and at City Clinic

Explore establishment of an STI collective impact initiative

- Evaluate capacity of SFDPH, Getting to Zero, or other citywide entities to establish and provide backbone support for an **STI collective impact initiative** with a strong steering committee.
  - Potentially manage this through the creation of an STI committee within Getting to Zero
  - Ensure that the steering committee includes representation from a **wide variety of stakeholders**, including the public health division of SFDPH, the San Francisco Health Network, community-based organizations, private providers, and consumers

Pillar 3, Activity 6. Improve options for harm reduction in substance use-related settings and other venues frequented by key populations.

Addresses: ***National Strategy 3b.*** *Increase availability, use, and access to and quality of comprehensive Syringe Services Programs (SSPs)*

Build capacity of staff who interact with and provide services for PWUD, especially those who use methamphetamine

- **Standardize training** for staff in city-operated and funded programs on how to engage marginalized or vulnerable communities in ways that **do not perpetuate trauma or stigma**, particularly if an interaction may feel challenging, unfamiliar, and/or unsafe
  - Topics can include, but not be limited to: harm reduction, cultural humility and sensitivity, de-escalation, motivational interviewing, building trust, social determinants of health, and drug effects and toxicity

Expand availability of treatment models across the continuum of harm reduction services

- Consider and implement some combination of services that include:
  - **Non-abstinence-based** residential treatment programs
  - **Residential step-down beds** available to clients exiting from residential treatment programs
  - Detox, psychiatric inpatient, and psychiatric emergency care placements for individuals experiencing methamphetamine-induced psychosis
  - **Low-threshold case management** and wrap-around services designed specifically to meet the unique needs of people who use methamphetamine
- **Include people with current and/or former experience** using methamphetamine and other drugs in the **planning and staffing** of harm reduction services and treatment programs
- Expand the use **contingency management** and medication support
- Improve availability of fentanyl and other **drug testing strips**
- Increase the availability of **safe indoor spaces** that provide low-threshold, harm reduction, and basic services, such as **drop-in centers** that provide hospitality, basic medical services, behavioral health services, counseling, and linkage to care
- Continue use of the **Managed Alcohol Program** to prevent life-threatening alcohol withdrawal and other health complications, particularly while COVID-19 restrictions are in place
- Expand use of **injectable buprenorphine**
- Make structural changes to increase the capacity for buprenorphine initiation at SFDPH's Office-Based Buprenorphine Induction Clinic (OBIC)
- Promote tobacco cessation for participants in substance use programs, and offer available therapies to support cessation
- Explore ways to prevent poor health outcomes related to cannabis use in youth, including development of a youth-focused cannabis prevention and education campaign
- Explore how to best **leverage the Drug Medi-Cal waiver** to improve the overall health of people who use drugs, including through increased HIV/HCV/STI testing and treatment, and naloxone provision
- **Advocate for state and federal policies that expand access** to low-threshold and long-term substance use treatment options. Policy changes to target include:
  - Expansion of services that are Medi-Cal reimbursable such as low-threshold services and contingency management interventions
  - Continuation of Medi-Cal benefits during incarceration
  - Removal of residential treatment episode limitations

3. Prevent

- o Authorization of paramedics to determine the most appropriate non-emergent site for transport
- o Regulatory change to allow people existing drug treatment programs (other than methadone programs) to receive naloxone upon exiting the program

Meth sobering site

- Create a trauma-informed **sobering site** specifically designed for people who use methamphetamine
- Integrate **harm reduction services** for individuals who are under the influence of methamphetamine
- Provide **on-site medication services** such as antipsychotics or sedatives if an individual presents with acute psychosis or agitation

Low-barrier medication assisted treatment

- Support efforts to **offer low-barrier MAT** for all substances (opioids, stimulants, alcohol, tobacco) at urgent care, SROs, all syringe access sites, Psychiatric Emergency Services, Dore Urgent Care Clinic, hospitals, and other relevant locations
- Support providers in **developing guidance** for how to reduce barriers to access and to train staff appropriately, particularly in clinical settings
- Increase the provision of **MAT in mobile settings**
- Provide information about **drug testing** services
- **Increase partnerships** between harm reduction programs and employment support services

Increased availability, use, and access to and quality of comprehensive Syringe Services programs (SSPs)

- **Provide SSPs** in the Bayview/Hunters Point neighborhood **through the M-HAPs**
  - o **Provide** sterile equipment, condoms, a safe and welcoming environment to get information and naloxone
  - o Provide **Referrals** to primary care and other services
  - o Provide **Linkage** to substance use treatment and HCV testing and treatment
- **Work with HSH, supportive housing site managers, and tenant leaders** to ensure residents and guests of at **shelters, navigation centers, supportive-housing sites, and SROs** have access to SSPs, overdose prevention, behavioral health, and sexual health services
  - o Align DHSH policies with SFDPH harm reduction policies, adjusting zero-tolerance shelter policies
  - o Pilot a harm reduction treatment program in an HSH-run Navigation Center
- **Pilot offering syringes at CBHS Pharmacy/HR360/substance use disorder / mental health programs**
- Contractually obligate SFDPH-funded drug treatment providers to provide referrals to syringe access
- Provide **training and certification** to CHEP programs to become part of the Syringe Programs (SP) Network
- Build on a recent pilot to offer syringe access and disposal at all sites where HIV/HCV/STI testing is offered
- Continue developing the SFDPH rapid-response team to **respond to safe disposal requests**, in conjunction with community-based clean-up teams and regularly-scheduled sweeps.

Pillar 3, Activity 7. Provide an array of supports to prevent overdose among the populations most affected by the HIV, HCV, and STI epidemics.

Addresses:
National Strategy 3b. Increase availability, use, and access to and quality of comprehensive SSPs

Expand naloxone availability

- Examine claims, pathways, and up front costs for **providing naloxone routinely in methadone programs**
- Increase **naloxone provision at primary care clinics** located in high-overdose neighborhoods, such as Tom Waddell Urban Health Clinic
- Expand the ability of the DOPE Project to provide naloxone, including a substantial increase in funding to support continued purchase and distribution of naloxone (particularly for high cost nasal naloxone)
- **Install naloxone vending machines** (managed/ stocked by the DOPE Project) at key city locations
- Improve consistency of training/carrying of naloxone among all police officers in the SFPD, by systematizing the police pilot and improving SFPD ambassadorship
  - o Develop a long-term funding strategy to **support police use of naloxone**
- Build in capacity to **assess naloxone prescribing in Epic**, to allow for continuous quality improvement

Safe consumption/injection sites

- Continue to advocate for **safe consumption/injection sites** with integrated services, inclusive of PrEP, HCV treatment, and HIV adherence support

3. Prevent

- Assemble data related to public health impacts of safe consumption/injection sites, to bolster advocacy

SRO overdose prevention and response

- Expand the Tenant Overdose Response Organizers (TORO) program to **address overdose prevention and response in single-room occupancy (SRO) hotels**
- Assess and adjust rules in SROs regarding guests, safe spaces, check-in policies (i.e. please check in X minutes), and emergency phone numbers to call in case of overdose
- Improve policies and structures to support frontline staff in supportive housing and shelters in responding to overdose through increased funding for the DOPE project to create culture change around overdose recognition and response in these settings

Overdose policies

- Address uneven preparation/response to overdose threat among SFDPH-funded agencies by **requiring on-site overdose response plans**, and adding overdose response deliverables to contracts, including training all staff on the overdose policy
- Ensure providers **maintain a supply of naloxone on site** to use for overdoses occurring on site
- Ensure providers designate an **overdose prevention liaison** on staff who will lead all overdose prevention efforts at the agency
- Ensure providers develop **active referral systems** and information packets for methadone or buprenorphine-based treatment initiation
- Require that **city-owned housing for >10 people** have all staff trained in the proper use of naloxone
- Require any city-owned building housing more than 10 people have **bio-hazard containers** on-site

Other overdose prevention interventions

- Host **overdose prevention trainings** and educational forums for clients at agencies
- Systematically incorporate questions about prior overdose experience and overdose knowledge during any client intake
- Assist providers to become **naloxone distribution sites**
- Partner with the DOPE Project to develop and release an ad **campaign to address stigma against PWUD** and increase overdose awareness among service providers and members of the general public
- Increase overdose interventions particularly in the **Bayview neighborhood**, which is underserved in terms of overdose prevention interventions
- Increase funding for overdose prevention services within **Jail Health Services**
- Build capacity for overdose prevention training and awareness within methadone programs

Crisis management

- Bolster resources to increase the city's behavioral health response (e.g., a **Crisis Intervention Team,** comprised of SFPD officers and SFDPH behavioral health clinicians), **as an alternative to calling 911**
  - Establish a system of on-call clinicians available for police consult, to allow for improved assessment and connection to treatment
  - Allow and access to the Crisis Intervention Team via 311 for the general public, and **promote availability widely** throughout the city
- Ensure law enforcement staff are trained to use an **integrated crisis intervention approach**
  - Expand officer Academy training on crisis intervention to **incorporate a trauma-informed lens** that focuses on **de-escalation** and harm reduction, with the goal of connecting individuals under the influence of methamphetamine or other drugs to services and care
  - Trainings could also include the identification of signs of methamphetamine-induced psychosis and circumstances for transporting an individual in crisis to various suitable locations for connection to the city's system of services

Pillar 3, Activity 8. Increase rates of housing among people living with or at risk for HIV, HCV, and STIs.

Subsidize

- Complete planning **and implement the MOHCD process for expanding housing subsidies,**[160] which includes a component specifically for PLWH

---

[160] Mayor's Office on Housing and Community Development. 2020-2025 HIV Housing Plan Strategies and Goals, draft April 2020.

3. Prevent

- **Revisit balance and quantity** of deep vs. shallow subsidies available in SF
- Make an **increased number of** deep and shallow **subsidies** part of the permanent City budget
  - **Explore** replacing "shallow and deep subsidies with **a single category of** long term, need based **subsidies** that vary based on eligibility criteria
  - **Increase subsidy dollar amounts** and **lower the threshold** for "below market rate" housing so that it is truly affordable to more people
- **Make subsidies flexible by a**llowing residents to vacate units for medical, substance use, and mental health treatment and be guaranteed return at completion of treatment
- **Remove subsidy "time out" provisions,** especially for vulnerable populations who are usually unable to rapidly find suitable housing
- Ensure eviction prevention and shallow subsidies are **targeted at situations that will prevent homelessness**
- Increase funds for **emergency eviction prevention** by 30%, allowing for:
  - **Subsidies for people at risk of eviction,** so that no one is ever evicted for purely financial reasons.
  - Provision of legal assistance
  - One-time back rent payments
  - **Temporary rent payment** during residential and/or medical payment
- Explore ways to **partner with the SF Housing Authority** to increase subsidy options

Build

- **Enter into new agreements** with developers currently building housing, to increase stock more rapidly
- Explore additional strategies to increase supply such as an increase in **master leasing** and gaining new private landlords willing to provide affordable housing options
- Reduce the **length and complexity of the permitting process** to prioritize development of affordable housing units
- Regulate that all **new construction** in SF must include affordable units starting immediately
- Ensure that available affordable housing is **safe, healthy, and well-maintained**
- Explore and conduct **cost modeling** for creative approaches to increase the housing supply for people living with or at risk for HIV, HCV, or STIs, **without unwanted displacement**

Incentivize

- Provide **incentives for property owners** to lease to people who have low income
- Make changes to **zoning** rules and permitting **fees** to increase rates of rentals for people with lower income
- Offer **property tax credits** for individual landlords who lease long-term, affordable rentals
- Establish a **first-right-of-refusal** program to incentivize private developers to sell properties first to the City or community groups
- Consider implementation of a hefty **vacancy tax**, to make it worthwhile to rent units

Collaborate

- Form a Housing Crisis **Task Force**, potentially the HIV Housing Workgroup
- Develop a coordinated, equitable, transparent **housing services continuum**, especially for those with complex health needs
- Allow for people to be **waitlisted** and continuously reprioritized until housing meeting their needs is located
- Establish an ongoing mechanism for overall **coordination and accountability** of the various City departments charged with addressing housing
- Increase collaboration/coordination with aging services providers to address housing needs of older adults
- Provide **HIV housing service trainings** available to HIV housing related services providers twice a year

Utilize technology

- **Centralize** the existing **housing placement systems** using a single technological solution
- Maintain a clinically-prioritized list of people requesting housing and type of housing needed
- Maintain a **real-time inventory** of all available units and beds across the spectrum of housing options
- Automatically **match** people to appropriate options **and reprioritize/rematch** as new individuals are added to the system or placed in housing
- Help housed people **step up or step down** into other types of housing as their needs change.

3. Prevent

Support
- Create additional supportive housing solutions, both stationary and roving
- **Protect** people with substance use disorders **from unnecessary evictions**
- Increase ability to **support people in stepping down** from high-threshold, expensive housing situations
- Develop a **universal housing service guide** to provide case managers/intake personnel access to resources
- **Preserve** Residential Care Facilities for the Chronically Ill **(RCFCIs)** for people who need them
- **Implement the findings** of the MOHCD *Strategic Assessment of HOPWA-Funded Residential Care Facilities for the Chronically Ill* Report.[161]
- Continue to assess the need for RCFCI-level care and **implement and sustain changes** based on assessment findings
- Ensure the **safety of residents** of RCFCIs during COVID-19
- Expand **safe-hold lockers and medication storage** facilities where people who are unhoused can store, access, and retrieve vital medications and naloxone without risk of loss or having them removed from their control by police, the Department of Public Works (DPW), or shelter staff.

Guarantee
- Guarantee **safe, stable housing immediately upon discharge** for people completing residential mental health and substance use treatment
- Provide **pre-release planning and coordination** for people with substance use and mental health disorders released from incarceration
- Ensure persons released from incarceration at **night** have **access to shelter and supportive staff** to meet them to help with immediate needs
- **Protect emergency, low-income, and subsidized housing** for people entering inpatient treatment facilities

Pay a living wage
- Provide **adequate salaries** for case managers and other direct service workers serving unhoused populations
- Provide a **cost of doing business increase** and a **cost of living increase** on all HIV prevention, care, and housing contracts (regardless of the funding source) annually
- Provide continuous City investment to **ensure nonprofits can pay staff a livable wage** as required by the Minimum Wage Ordinance
- Continue to make critical investments in the **Nonprofit Sustainability Initiative** to help nonprofits achieve or maintain livable wages

Problem-solve
- Provide **housing ombudspersons** in each Board of Supervisor's office to resolve problems of persons who are unable to find affordable housing or are living in unsafe or otherwise unsuitable housing situations
  - Property owners with vacant units to offer can also contact the ombudsperson to ensure their units are considered as options for unhoused people
- **Work with partners** such as the SF Apartment Association and the SF Rent Board to allow private homeowners to gain renters

Collect and share data
- **Accurately document** all housing requests on an ongoing, real-time basis
- Use these data for **evaluation and continuous quality improvement** of our city's housing placement systems
- **Publicly report data in aggregate** on a regular basis, building trust in the system and a community-wide commitment to addressing the housing crisis by allowing for transparency and systems accountability with a set of clear, public-facing metrics

Pillar 3, Activity 9. Routinely collect, analyze, and publicly report comprehensive information about viral hepatitis epidemiology and outcomes, particularly for HCV.

Annual public reporting
- Beginning in 2021, **release a comprehensive annual Viral Hepatitis Report** that provides data and

---

[161] San Francisco Mayor's Office of Housing and Community Development. (2020). Strategic Assessment of HOPWA-Funded Residential Care Facilities for the Chronically Ill (RCFCIs).

3. Prevent

estimates of the numbers and types of people being tested and diagnosed with acute and chronic HCV infection, as well as the numbers and types of people being treated and successfully cured of their infections

- o **Use the information in this report for resource prioritization** regarding quantity and targeting of HCV-related prevention services (including treatment as prevention) by End Hep C SF and SFDPH
- o **Ensure that information is disseminated with lay language**, so that all people at risk for and living with HCV can benefit from sharing of these publicly-collected data

Pillar 3, Activity 10. Conduct an assessment of the City Clinic infrastructure to document HIV and STI prevention services including PrEP, identify gaps, and improve service quality.

Addresses:
National Strategy 3a. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP

Infrastructure assessment

- Conduct a **detailed assessment** of City Clinic infrastructure and service quality
- Review CDC recommendations for STI quality clinical services to identify gaps in services and how to fill them
- Employ LEAN results-based accountability methodology for quality improvement and to **address opportunities** identified through the Infrastructure Assessment
- Use quality improvement tools to **evaluate City Clinic workflows,** increasing efficiency
- Deploy a detailed project plan for implementing new strategies to offer more visits at City Clinic for **enhanced STI screening** and HIV services including PrEP, and **integrate additional HIV prevention services**
- Address billing related gaps, possibly through scaling up 3rd party billing, or establishing a 340b contract

Community Perspectives Assessment

- Conduct a **Community Perspectives Assessment** with patients and community members to better understand why those who are most vulnerable to HIV infection do and do not seek services at City Clinic
- **Adapt and market City Clinic services** to ensure these communities feel well served, including through **optimizing and promoting** City Clinic's services and website (http://www.sfcityclinic.org)

Enhance express services and address clinic efficiencies

- **Synergize** City Clinic express services with the "TakeMeHome" HIV/STI testing program
- **Promote "TakeMeHome"** as part of a broader SF sexual health social marketing campaign
- Implement and evaluate a **tablet or computer-based sexual risk assessment** completed by the patient before seeing a clinician, **to facilitate triage** to non-clinician patient care enabled by standardized orders
- Work with the SF Public Health Laboratory to **validate the Cepheid point-of-care** HIV viral load assay

Leverage opportunities afforded by EPIC

- Fully leverage opportunities to **expand and enhance integrated STI/HIV services** afforded by an upcoming, planned transition to the SFDPH-wide enterprise electronic health record, EPIC.
- Deploy EPIC at City Clinic to maximize Medicaid and commercial billing capacity, and improve STI/HIV care coordination across SFDPH providers
- Support STI/HIV quality improvement work at clinics serving patients vulnerable to STIs by developing **EPIC reports/dashboards to monitor STI screening rates**
- **Create a PrEP registry in EPIC** for panel management of City Clinic and SFHN PrEP patients.
- Provide **tailored feedback** of implementation of STI quality clinical services across the SF Health Network

Pillar 4 Activities: Respond

San Francisco has plans in place to rapidly identify, and respond to emerging HIV transmission clusters and outbreaks, prioritizing transmission clusters that are concerning for recent and ongoing transmission for rapid intervention and partner services. SFDPH has implemented Secure HIV-TRACE to analyze HIV nucleotide sequences and identify molecular clusters at the local level, conducting time-space analyses to detect diagnoses clustered in time and space and sharing findings with the LINCS team for follow up. The SFDPH HIV surveillance team and LINCS work together to locate rapidly identify and link persons in transmission clusters to care and provide testing and linkage to their named partners.

However, as important as this strategy is for preventing HIV transmission in San Francisco, we must also pay close attention to community concerns about privacy and government data sharing, especially in relation to illegal activities (such as drug use or sex work) or immigration status. <u>Words such as "molecular clusters," "surveillance," and "viral sequencing" must be avoided or clearly and thoughtfully explained</u>, so as to reassure people mistrustful of the medical community or harmed by our legal and immigration systems that they are not being placed at increased risk as a result of these activities.

Networks of concern and populations prioritized for intervention under this Pillar in San Francisco include: 1) networks with recent ongoing transmission, 2) persons with poor outcomes such as unsuppressed viral load, 3) vulnerable populations such as PWUD, 3) persons with drug resistance strains of HIV, 4) persons with Stage 0 (acute) HIV infection, and 5) persons identified through HIV-TRACE who are also on an existing Data-to-Care list.

4. Respond
Pillar 4, Activity 1. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response.
Addresses: *National Strategy 4a. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response* *National Strategy 4b. Investigate and intervene in networks with active transmission* *National Strategy 4c. Identify and address gaps in programs and services revealed by cluster detection and response*
Improve preparation and capacity for effective cluster response • Develop an HIV **cluster and outbreak response plan** • **Hire and train** a disease control investigator within LINCS, to focus on cluster response working alongside HIV/HCV/STI prevention and care staff at SFDPH and community-based organizations • Organize **quarterly updates** to the HIV Community Planning Council regarding cluster response • Continue weekly city-wide HIV care coordination calls, which include Jail Health, multiple community-based organizations, HIV care providers, and Getting to Zero case managers to find and re-link people living with HIV • Hold monthly meetings with a standing committee to **review and prioritize identified clusters** and determine appropriate actions • Add language regarding cluster response to new SFDPH contracts with community-based organizations to **ensure that there are agreements in place** to work efficiently and effectively during a cluster response • **Work with community leaders** long-term to build trust • **Carefully develop messaging** to address community concerns around confidentiality

4. Respond

Flexible funding mechanisms

- Identify **flexible funding mechanisms** to respond to an HIV outbreak
- Utilize the **National Incident Management System** to manage and coordinate emergency responses

Cluster data system

- **Develop a data system** to rapidly analyze, integrate, and visualize cluster data
    - **Utilize and integrate existing data** for cluster identification, investigation, and intervention
    - **Consider additional data sources** based on the needs and characteristics of clusters and outbreaks identified
- **Analyze HIV sequence data** using Secure HIV-TRACE (See Pillar 4, Activity 2)
    - Use ISCHTR to manage cluster-related navigation data.

Identify and address gaps in programs and services revealed by HIV cluster detection and response

- Build on prior experiences to address any concerns or gaps identified by cluster investigation work, and incorporate the necessary changes into our cluster response plan
- **Hire an epidemiologist** to support cluster activities for expanded epidemiologic and analysis needs across SFDPH branches, including for HCV and STIs

Pillar 4, Activity 2. Investigate and intervene in networks with evidence of active HIV transmission.

Addresses:

National Strategy 4a. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response

National Strategy 4b. Investigate and intervene in networks with active transmission

National Strategy 4c. Identify and address gaps in programs and services revealed by cluster detection and response

Identify transmission clusters

- Run Secure HIV-TRACE on a weekly basis to identify:
    - Transmission clusters with recent ongoing transmission
    - Persons in a transmission cluster with poor health outcomes such as an unsuppressed viral load,
    - Clusters of people from vulnerable populations such as PWID
    - Clusters with persons diagnosed with Stage 0 (acute) HIV infection
- **Share information with the LINCS team** for location, linkage to care, and offer testing and linkage to their named partners
- **Use thoughtful messaging when tracing and linking** to reassure people disproportionately harmed by our legal and immigration systems of their privacy and safety during this process

Respond to clusters or outbreaks

- In the event of a cluster or outbreak, **ARCHES-HIV Surveillance and LINCS will partner** to rapidly locate and link people in the cluster to care, and provide testing and linkage to named partners
- In an outbreak, **use existing case conference mechanisms to locate persons in a cluster network** within 7 days of identification
- Combine information from Secure HIV-TRACE with routine Data-to-Care activities to prioritize persons of concern for immediate outreach and intervention.
    - **Match** persons identified through as being in a transmission cluster with routinely run Data-to-Care lists.
    - **Prioritize** persons identified in HIV-TRACE who are also on a Data-to-Care list for outreach by LINCS.

Cooperate with multi-jurisdictional investigations of HIV transmission clusters

- Investigate, locate and link to care **San Francisco cases identified by CDC** as being in a multi-jurisdictional transmission cluster
- Work with the California Department of Public Health to investigate and intervene on clusters with persons in multiple California counties

4. Respond

Pillar 4, Activity 3. Identify populations experiencing increases in new HIV diagnoses by running the CDC time space analysis program.

Addresses:
National Strategy 4c. Identify and address gaps in programs and services revealed by cluster detection and response

Time-space program
- Run the CDC time-space program (modified) monthly, to **identify neighborhoods experiencing increases** in new diagnoses
- **Develop local criteria** to prioritize transmission clusters, and local protocols to investigate transmission clusters of concern
- **Share information** from these analyses with LINCS, so they can locate and link people to care and provide testing and linkage to their named partners

Pillar 4, Activity 4. Regularly monitor drug-resistant strains of HIV.

Addresses:
National Strategy 4b. Investigate and intervene in networks with active transmission
National Strategy 4c. Identify and address gaps in programs and services revealed by cluster detection and response