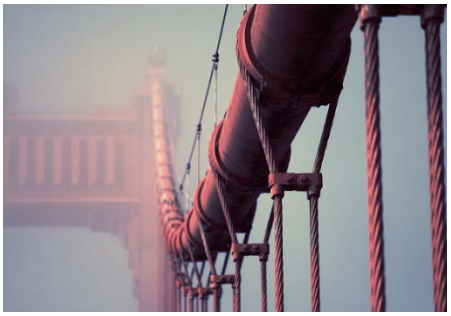

The Jurisdictional HIV Prevention Plans for the San Francisco Metropolitan Statistical Area 2012-2016

A Report to the Centers for Disease Control & Prevention

Submitted by:

San Francisco Department of Public Health
Marin County Department of Health & Human Services
San Mateo County Health System

February, 2013

The San Francisco Metropolitan Statistical Area

The San Francisco Metropolitan Statistical Area (MSA) is comprised of the City & County of San Francisco, the County of Marin, and the County of San Mateo. This document is divided into three parts, one for each county. The three counties have a strong collaboration and similar approach to HIV prevention, but different levels of resources and different activities, thus the need for separate parts.

Part 1:
The San Francisco HIV Prevention Strategy, 2012-2016: An Integrated Citywide Approach
Submitted by the San Francisco Department of Public Health (SFDPH)
pp. 2-86

Part 2:
Jurisdictional HIV Prevention Plan for Marin County, 2012-2016
Submitted by the Marin County Department of Health and Human Services (MCDHHS)
pp. 87-93

Part 3:
Jurisdictional HIV Prevention Plan for San Mateo County, 2012-2016
Submitted by the San Mateo County Health System (SMCHS)
pp. 94-102

PART 1

The San Francisco HIV Prevention Strategy, 2012-2016: An Integrated Citywide Approach

Acknowledgements

The HIV Prevention Planning Council and the SFDPH would like to thank all the community members, SFDPH staff, researchers, and other HIV and health experts that contributed to the development of this Strategy. Special acknowledgement goes to SFDPH staff: Emalie Huriaux for facilitating the development and writing of this document; Oscar Macias for layout and design; Laurel Bristow for assembling the references; and Michael Paquette for coordination across the San Francisco MSA. Special thanks to Susan Scheer, Director of the SFDPH HIV Epidemiology Section, and H. Fisher Raymond, Director of Bio-Behavioral Surveillance, SFDPH HIV Epidemiology Section, for contributing their expertise and data for the HIV prevention, care, and treatment cascade and data from the local National HIV Behavioral Surveillance surveys and the San Francisco HIV consensus process, respectively.

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City and County of San Francisco

Department of Public Health
HIV Prevention Section

EDWIN M. LEE
Mayor

November 8, 2012

Dear HIV Prevention, Care, and Treatment Leaders and Partners,

On behalf of the San Francisco Department of Public Health (SFDPH), I am pleased to present *the San Francisco HIV Prevention Strategy, 2012-2016: An Integrated Citywide Approach*.

This document synthesizes the hard work of the San Francisco HIV Prevention Planning Council (HPPC), the HIV Health Services Planning Council, the SFDPH, and numerous community partners to create a continuum of HIV prevention, care, and treatment services, grounded in local HIV epidemiology, research, and community values.

San Francisco has a strong history of leadership addressing HIV. Our efforts have brought a leveling of new infections, with some indication of a downward trend. HIV, once epidemic, is now considered endemic (persistent and established) in San Francisco. While we have seen some success, high prevalence populations continue to exist: males who have sex with males (MSM); transgender females who have sex with males; and injection drug users. In addition, there are populations disproportionately impacted by HIV-related morbidity and mortality, particularly Latino and African American MSM. Given these disparities and the endemic state of HIV, we must refocus our efforts by promoting scalable, innovative, integrated, effective interventions reaching high-prevalence populations. In addition, we must promote structural approaches to curb new infections and ensure people living with HIV achieve optimum health.

Our local leadership, coupled with action at the federal level through the National HIV/AIDS Strategy and the Affordable Care Act, and the growing body of research showing treatment as prevention, make this an exciting and hopeful time for addressing HIV in San Francisco.

We look forward to reviewing the success of the San Francisco HIV Prevention Strategy in the years to come. The SFDPH will work with the HIV planning councils to update the Strategy annually, as needed, to ensure we reach our goal—to reduce new infections by 50% by 2017.

Sincerely,

Tracey Packer, MPH
Acting Director of HIV Prevention
Government Co-Chair, HIV Prevention Planning Council

City and County of San Francisco
Mayor Edwin Lee

Department of Public Health
Barbara A. Garcia, MPA
Director of Health

November 8, 2012

Mr. Robert Swayzer
Grants Management Officer
Grants Management Branch, Procurement and Grants Office
Funding Opportunity Announcement PS12-1201
Centers for Disease Control and Prevention, MS E-15
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146

Dear Mr. Swayzer:

On behalf of the members of the San Francisco HIV Prevention Planning Council (HPPC), we are pleased to provide this "Letter of Concurrence" to the San Francisco Department of Public Health (SFDPH), HIV Prevention Section (HPS) in response to Funding Opportunity Announcement PS12-1201.

The HPPC has reviewed the San Francisco Jurisdictional HIV Prevention Strategy that is to be submitted to the Centers for Disease Control and Prevention (CDC) and ***concurs*** that the Jurisdictional HIV Prevention Strategy describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease.

The HPPC was actively involved reviewing the development of the San Francisco Jurisdictional HIV Prevention Strategy. During the past few months, members of the HPPC and other stakeholders received a series of opportunities to provide input on the narrative for the strategy:

- Presentation to HPPC regarding Jurisdictional & Comprehensive Plans on August 9
- Presentation to HHSPC regarding Plans on August 20
- Presentation to San Mateo & Marin Counties on August 27
- Presentation to HIV Testing Coordinators on September 14
- Discussion with Joint HIV Prevention & HIV Health Services Sections planning group on September 20
- Presentation to the HIV/AIDS Providers Network on October 5, 2012
- HPPC working group met September 4, October 1, October 10, October 15
- Presentation to the Transgender Advisory Group on October 16

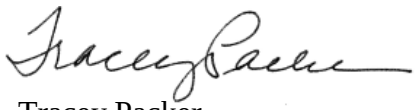
- HPPC Executive Committee met October 25
- HPPC meeting to present for concurrence on November 8

The final Jurisdictional Plan was discussed at the full November Council meeting, when a motion was made, seconded and unanimously approved by the membership.

These deliberations demonstrate the effective and on-going partnership between the community planning group and the SFDPH. Should you wish additional information regarding this letter and/or HPPC involvement in preparation of the San Francisco Jurisdictional HIV Prevention Strategy, let us know.

We appreciate the CDC's continuing support for the San Francisco's HIV prevention efforts.

Sincerely,



Tracey Packer	Jose Luis Guzman	David González
Health Department Co-Chair	Community Co-Chair	Community Co-Chair

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Executive Summary

HIV is no longer epidemic in San Francisco; it is endemic (persistent and established), and thus requires a shift in how we approach HIV prevention. Approximately 207-429 people continue to become infected each year. It is estimated that 15% of the nearly 19,000 people living with HIV/AIDS (PLWHA) are unaware of their status. Current HIV testing frequency among high-prevalence populations [i.e., males who have sex with males (MSM), injection drug users (IDU), and transfemales who have sex with males (TFSM)] is insufficient to reduce the unknown infection rate (70,000 more tests are needed annually). One in four PLWHA are not engaged in primary medical care, and 28% of PLWHA who know their status have unsuppressed viral load. HIV prevalence increases every year due to longer survival and a rate of new infection that more than replaces deaths due to AIDS. Thus, the endemic state of HIV is no cause for complacency.

In order to address these unmet needs and reduce new HIV infections, particularly in light of current reductions in HIV-related resources, San Francisco is implementing a more upstream, structural approach to HIV prevention, including expanding testing and treatment access. This Strategy includes a combination of interventions that reduce community-level risk for HIV. The goal is to suppress individual and community viral load, thereby improving individual health and reducing HIV transmission risk at the community level.

The San Francisco Department of Public Health(SFDPH) and the HIV Prevention Planning Council (HPPC) have set the following goal: **to reduce new HIV infections by 50% by 2017**. Our specific objectives are to:

- **Reduce new HIV infections among MSM by 50%;**
- **Reduce new HIV infections among TFSM by 50%;**
- **Eliminate new infections among IDUs;**
- **Eliminate perinatal infections; and**
- **Reduce disparities in new HIV infections.**

The Strategy was developed by taking into account the effectiveness, scalability, cost, and potential impact of each intervention. Our HIV efforts focus on reaching the individuals at highest risk for HIV with primary prevention and testing efforts and to ensure those living with HIV are reached by a continuum of secondary and tertiary prevention efforts – that they know their status, receive partner services, are linked to care, remain engaged in care, and achieve viral suppression.

The Strategy includes maintenance and scale up of existing efforts as appropriate, in areas where we have already shown substantial success (e.g., syringe and condom access, perinatal prevention, and post-exposure prophylaxis).

Notes on Language

To minimize the use of abbreviations, when the term "males who have sex with males (MSM)" is used, it is intended to be inclusive of males who have sex with males and females (MSM/F); transmales who have sex with males (TMSM); and MSM-injection drug users (MSM-IDU), unless otherwise indicated.

When the term "injection drug user (IDU)" is used, it is intended to be inclusive of all IDU who are not MSM or transfemales who have sex with males, unless otherwise indicated.

When the term "transfemales who have sex with males (TFSM)" is used, it is intended to be inclusive of TFSM-IDU, unless otherwise indicated.

In San Francisco, the way we describe individuals in the acute stage of HIV infection presents a challenge between scientific accuracy and cultural competence. Individuals who are acutely infected (i.e., reactive on a test that looks for HIV itself and not antibodies to HIV) are not technically "HIV positive." HIV positive is a diagnostic term indicating the detection of HIV antibodies. Labeling individuals in the acute stage of infection as "HIV infected" elicits concerns from some community stakeholders about HIV-related stigma. In the *San Francisco HIV Prevention Strategy, 2012-2016: An Integrated Citywide Approach*, the term "HIV positive" is used to describe individuals living with HIV, including those in the acute state of infection.

Introduction

HIV is no longer epidemic in San Francisco (see figure below);[1] it is endemic (persistent and established), and thus requires a shift in how we approach HIV prevention (figure 1). When HIV was epidemic, behavioral interventions for HIV-positive and high-risk HIV- negative people were the centerpiece of the local strategy. Exciting advances in HIV science and technology in recent years have provided us with a broader array of tools to address HIV than we have ever had before. Behavioral interventions are now one of many tools in the prevention toolbox. *The San Francisco HIV Prevention Strategy, 2012-2016: An Integrated Citywide Approach* (the Strategy) articulates how we are adjusting our portfolio to ensure the best possible health outcomes for people at risk for and living with HIV.

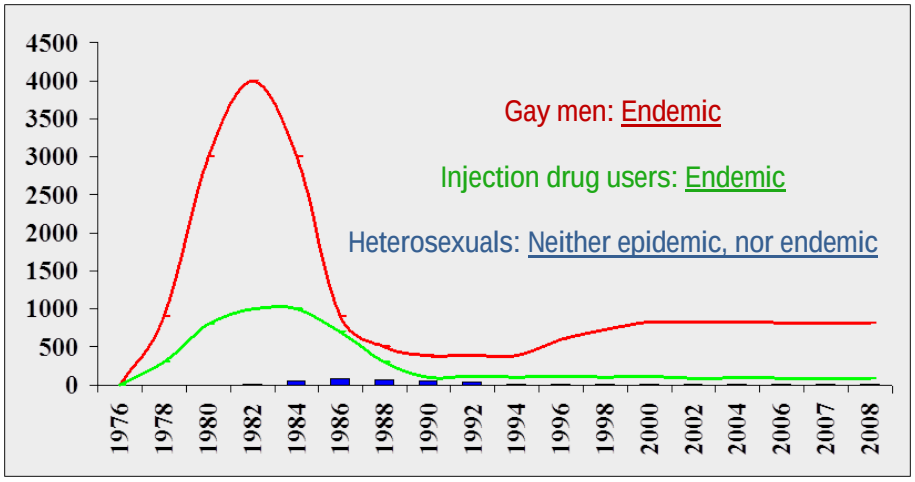
The state of HIV in San Francisco 2012

1. Hyper-endemic among MSM.
2. Endemic among IDU.
3. Hyper-endemic among TFSM.
4. Disproportionate burden of HIV and poorer health outcomes among African Americans, regardless of behavioral risk, compared with other races/ethnicities.
5. Few, sporadic cases in non-IDU heterosexual women and men.
6. Elimination of perinatal cases, indirectly linked to the above populations.

For more information about the endemic in San Francisco, see 2010 HIV Prevention Plan, Chapter 1: Epidemiologic Profile, and 2011 SF HIV Epi Report

Local Epidemiology

Figure 1. Estimated HIV incidence, San Francisco



Approximately 207-429 people continue to become infected each year in San Francisco.[2] It is estimated that 15% of the nearly 19,000 people living with HIV/AIDS (PLWHA) are unaware of their status.[3] Current HIV testing frequency among high-prevalence populations [i.e., males who have sex with males (MSM), injection drug users (IDU), and transfemales who have sex with males (TFSM)] is insufficient to reduce the unknown infection rate (70,000 more tests are needed annually).[3] One in four PLWHA are not engaged in primary medical care,[4] 28% of PLWHA who know their status have unsuppressed viral load, and 50% of newly diagnosed remain unsuppressed within a year of diagnosis.[2,5] HIV prevalence increases every year due to longer survival and a rate of new infection that more than replaces deaths due to AIDS.[2] Thus, the endemic state of HIV is no cause for complacency. These trends must be taken into account in determining how best to deliver HIV prevention services in San Francisco.

The San Francisco HIV Prevention Strategy

In order to address these unmet needs and reduce new HIV infections, San Francisco is implementing a more upstream, structural approach to HIV prevention, including expanding testing and treatment access. This Strategy represents such an approach by presenting a combination of interventions that reduce community-level risk for HIV. Based on a growing body of evidence that viral load suppression greatly reduces transmissibility , the goal is to suppress individual and community viral load, thereby improving individual health and reducing HIV transmission risk at the community level,.[6] Ample science exists to support San Francisco's Strategy. The Strategy was developed by taking into account the effectiveness, scalability, cost, and potential impact of each intervention. Recent modeling shows that focusing on expanding testing and treatment access could achieve a 76% reduction in new HIV infections by 2014.[7]

Specifically, a primary focus of this Strategy is a scale up of a continuum of services for HIV-positive people, from initial diagnosis through accessing and maintaining care and treatment. This scale up includes increased HIV testing (both targeted community-based testing, as well as routine screening in clinical settings), expanded partner services, and augmentation of existing linkage to care, re-engagement in care, and treatment adherence efforts.

The benefits of this new upstream approach will only be realized if community and individual norms and skills for practicing safer sex and other harm reduction approaches are supported and promoted. Therefore, San Francisco continues to support behavioral interventions for HIV-positive and HIV-negative people in a more concentrated, scaled down way than we have in the past. Such interventions focus on individuals in high-prevalence groups and groups disproportionately affected by HIV: HIV-positive individuals with unsuppressed viral loads, MSM, Latino MSM, African American MSM, MSM who use substances, and TFSM.

San Francisco's Strategy largely includes maintenance of existing efforts and scale up, as appropriate, in areas where we have already shown substantial success: syringe access, perinatal prevention, condom access, and non-occupational post-exposure prophylaxis (nPEP).

National HIV Behavioral Surveillance (NHBS) data for San Francisco shows that MSM and IDU report high levels of access to condoms and IDU report high levels of access to syringes. With a relatively small increase in investment, we strive to increase access even further and potentially realize a great impact. Other successful efforts, such as perinatal prevention and non-occupational post-exposure prophylaxis (nPEP), are maintained at current levels.

Goals and Objectives

In balancing the challenges of addressing HIV in San Francisco with our community experience and evidence-based perspective, the SFDPH and the HPPC have set the following goal – to **reduce new HIV infections by 50% by 2017**. Our specific objectives are to:

- **Reduce new HIV infections among MSM by 50%;**
- **Reduce new HIV infections among TFSM by 50%;**
- **Eliminate new infections among IDUs;**
- **Eliminate perinatal infections; and**
- **Reduce disparities in new HIV infections.**

The primary goals of the National HIV/AIDS Strategy (NHAS)[8] align with San Francisco's goal and objectives and support local efforts. The NHAS goals are*:

1) Reduce new HIV infections;
2) Reduce HIV-related health disparities
3) Increase access to care and optimize health outcomes for PLWHA

Summary of the San Francisco HIV Prevention Strategy			
Type of Intervention/ Service	Examples	Change in Scale from Previous Years	Related NHAS Goals*
Continuum of services that will ultimately reduce community viral load	HIV testing (in clinical and non-clinical settings), linkage to HIV primary care, partner services, retention/re-engagement in care, treatment adherence	Scale up	1, 2, 3
Behavioral interventions	Behavioral risk screening and behavioral risk reduction interventions for HIV-positive and high-risk HIV-negative people	Scale down	1, 2
Low-cost, high-impact interventions	Condom distribution, syringe access and disposal	Scale up	1, 2
Successful cost-effective efforts	Perinatal prevention, nPEP	No change	1, 2
New services	PrEP	Launched	1, 2

Underlying Principles

The following principles underlie our approach to reducing new HIV infections in San Francisco[9]:

1. *Health and wellness for individuals and communities.* Health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (World Health Organization Constitution).[10] Health is influenced by multiple factors, including psychological, physical, social, structural, and political. HIV prevention efforts must consider health in this broad context to have a lasting effect on individuals and communities.

2. *Prevention with both HIV-negative and HIV-positive individuals.* HIV prevention should reach those at risk for HIV, as well as those who are living with the virus. Specific and different messages and interventions may be appropriate for these two groups; on the other hand, common interventions salient to both groups are also important because affected individuals co-exist in common communities.

3. *Prevention and treatment go hand-in-hand.* A comprehensive prevention approach recognizes that treatment is a vital part of prevention, whether treatment is for substance use, mental health, or HIV. With regard to HIV specifically, a reduction in HIV viral load not only increases lifespan and quality of life, it also reduces infectiousness and the likelihood of HIV transmission.

4. *End disparities.* We know who is at highest risk for HIV in San Francisco: MSM (particularly white, African American, and Latino MSM), TFSM, and IDU. Our efforts must be prioritized to focus on these populations and communities for us to have the greatest chance of reducing HIV incidence.

5. *Evaluation is key to the success of prevention.* We must evaluate our programs to know what is working and how to best serve the people we need to reach. Evaluation is critical in determining whether prevention resources are being used most effectively.

6. *Collaboration between science and community.* The best HIV prevention happens when community input and science work together to create a full picture of what is going on and what needs to happen. The community planning process is one way this occurs. The San Francisco Department of Public Health (SFDPH), in collaboration with the HIV Prevention Planning Council (HPPC) (our local HIV Prevention Community Planning Group) and other community partners, is committed to providing leadership to make sure that San Francisco always takes both science and community values into account.

Summary

Using these principles, we must continue our efforts to eliminate new HIV infections. Of course, we must take into account the many challenges involved in achieving this ultimate goal, including fiscal constraints, and the need to deliver prevention interventions to more people in the high-prevalence populations (i.e., MSM, IDU, TFSM).

Focusing prevention efforts on MSM, IDU, and TFSM is also prevention for non-injecting biological women and men who have sex exclusively with women. Because most transmission within these groups is due to sexual transmission from HIV-positive MSM and female or male IDU, preventing new infections and supporting testing and treatment access among these groups will lead to increased viral load suppression and, therefore, reduced transmissibility.

Within San Francisco, one person per day becomes infected with HIV. Local data illustrates a "relentless inevitability" of HIV among MSM – an estimated 20% of MSM in San Francisco will become infected with HIV by 51 years of age[11]. Communities must be full partners as we face the challenging task of treating and preventing HIV. We are committed to ending new HIV infections, eliminating the health disparities underlying HIV, and promoting health and wellness for all.

The HIV Prevention, Care, & Treatment Cascade

In San Francisco we are expanding the concept of the "treatment cascade"[12] to describe our approach to the continuum of HIV prevention, care, and treatment and to describe the number of individuals at risk for and living with HIV/AIDS who are actually receiving the full benefits of the prevention, care, and treatment services they need. Our HIV efforts focus on reaching the individuals at highest risk for HIV with primary prevention and testing efforts and to ensure those living with HIV are reached by secondary and tertiary prevention efforts – that they know their status, are linked to care, remain engaged in care, and achieve viral suppression. Viral suppression, achieved through secondary and tertiary prevention efforts, is ultimately a primary prevention strategy for HIV-negative individuals.

Three levels of HIV prevention

Primary prevention: Public health activities designed to prevent new HIV infections (i.e., activities to keep HIV-negative people negative).

Secondary prevention: Public health activities designed to detect HIV early and link people to care.

Tertiary prevention: Public health activities aimed at slowing the progression of HIV and keeping people living with HIV healthy.

Figure 2.

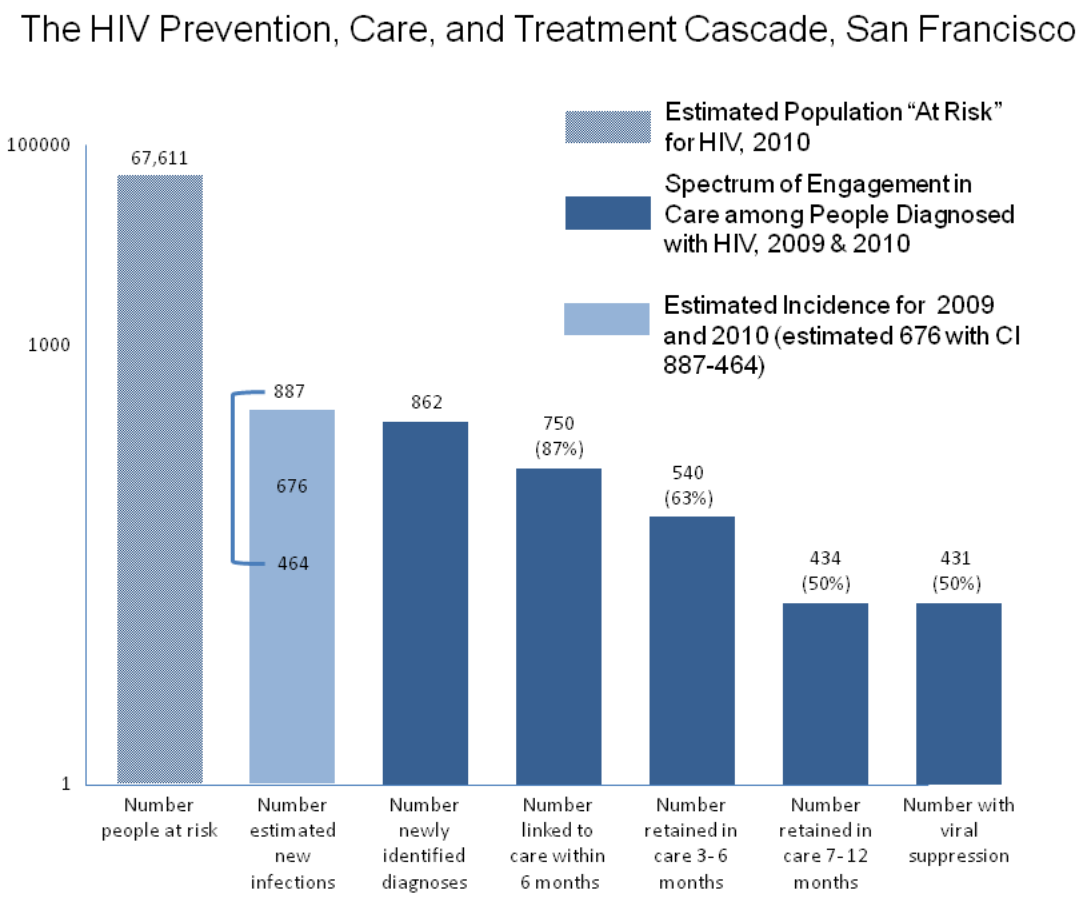
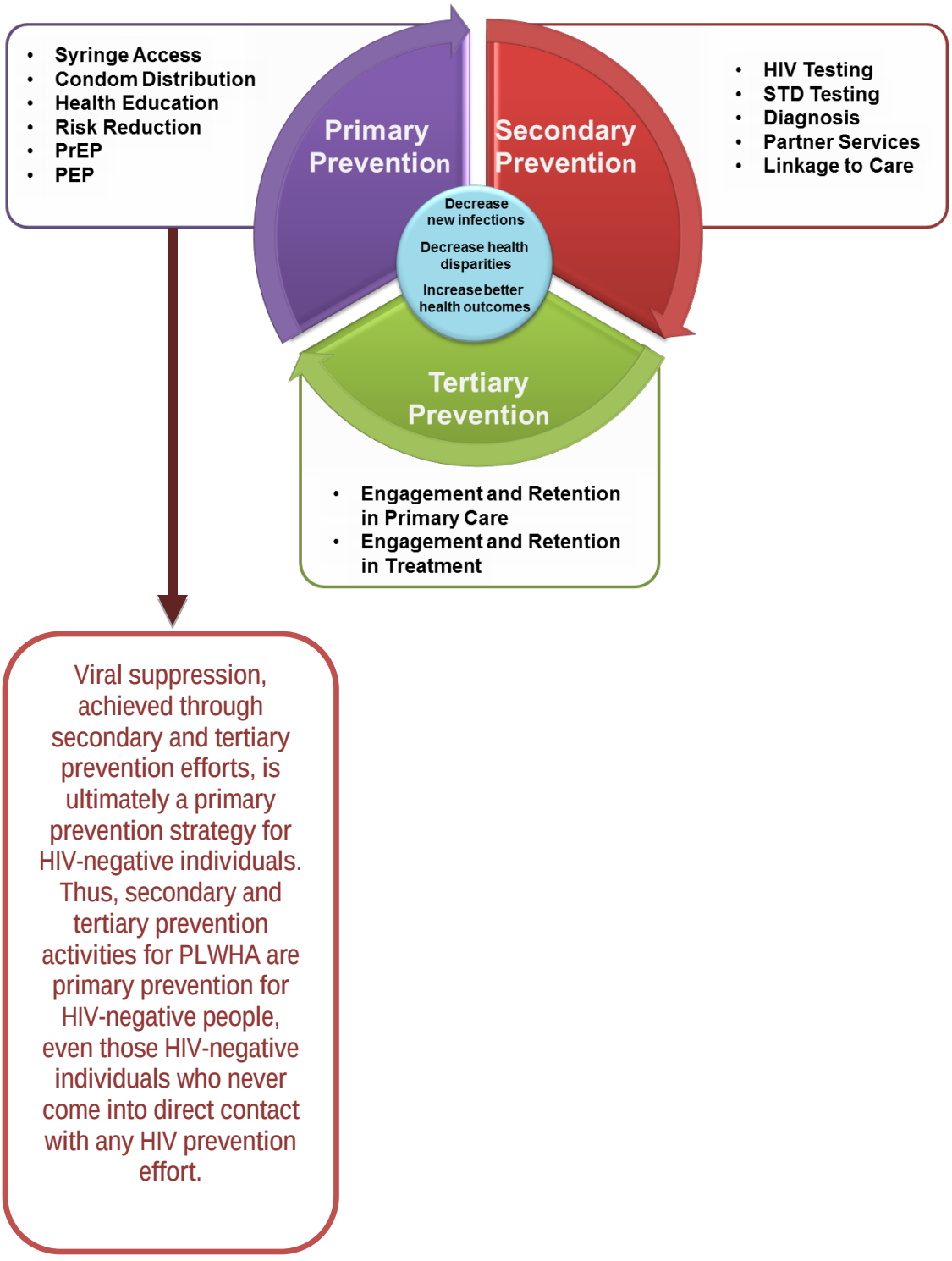


Figure 3.

San Francisco's Approach to Maximizing the Continuum of Prevention, Care and Treatment



Three Levels of HIV Prevention (Figure 3)

Primary prevention efforts attempt to reach the 67,561 people estimated to be at risk for HIV in San Francisco (over 8% of the population).[3] These efforts include syringe access and disposal services; condom distribution; health education and risk reduction programs to address drivers (for more on drivers see pages 54-55); and pre-exposure prophylaxis (PrEP) and nPEP. Males who have sex with males and MSM who inject drugs comprise 72% of the at-risk population and MSM, IDU and TFSM combined comprise 92% of the at-risk population. Thus, these populations are the focus of primary prevention efforts in San Francisco. In addition to reaching individuals at risk for HIV in San Francisco, primary prevention efforts, such as syringe access and disposal and condom distribution, reach individuals living with HIV to assist them in achieving optimal health and avoiding the transmission of HIV to others.

Secondary prevention efforts attempt to reach the individuals who are *diagnosed* with HIV (approximately 862 in years 2009 and 2010 combined) and the estimated 207 to 429 individuals who become *newly infected* with HIV each year (i.e., incident infections) (figure 2). In addition, secondary prevention efforts attempt to reach all individuals living with HIV who have not been linked to care.* These efforts include expansion of HIV testing in community-based and clinical venues, partner services, and linkage to care efforts. The SFDPH supports community-based testing efforts that: 1) aim to increase frequency of HIV testing among MSM, IDU, and TFSM citywide; 2) help people living with HIV who are unaware they are HIV-positive learn their status; 3) support initial linkage to primary care, partner services, and ancillary services for people testing HIV-positive; and 4) provide people who test HIV-negative with the information, resources, and support to stay negative.

Tertiary prevention efforts attempt to reach all individuals living with HIV, including the newly diagnosed individuals linked to care each year (approximately 750 in years 2009 and 2010 combined), to ensure they remain engaged in care and, ultimately, achieve viral suppression (figure 2). Never before have prevention, care, and treatment services been as aligned as they are today. We know that HIV-positive individuals with suppressed viral loads have improved health outcomes ***and*** are less likely to transmit HIV to others, compared with individuals who are not virally suppressed.[7,13-25] It is clear that engagement and retention in care is good for both individual health and public health. All efforts to support the health of PLWHA are HIV prevention.

Tertiary prevention efforts include all HIV care and treatment activities, as well as Prevention with Positives (PWP) programs to support individuals to fully engage in their care so that they can experience the best possible health outcomes and reduce opportunities for HIV

* Note that the framework of the Cascade was developed not only to illustrate the current state of HIV in San Francisco, but also to provide baseline against which we can measure the impact of the Strategy over time. The population of all PLWHA known to the SFDPH is much larger, at over 15,000 individuals, as indicated in the *SFDPH HIV/AIDS Epidemiology Annual Report, 2011*.

transmission. Program activities include treatment adherence; engagement in HIV care; disclosure assistance; health education/risk reduction to address HIV risk behavior; linkage to ancillary services (to meet client needs and address barriers to adherence, engagement, and risk reduction); and STD, viral hepatitis, and tuberculosis screening and treatment. Programs also include a prevention case management (PCM) component.

The SFDPH recently established the Linkage, Integration, Navigation, and Comprehensive Services Team (LINCS), which works at the primary, secondary and tertiary prevention levels. LINCS works at the secondary and tertiary prevention levels to identify, locate, and connect those who have tested positive to HIV care services and to ensure those who have fallen out of care are re-engaged. In addition, LINCS works with these individuals to support notifying their sexual and/or needle-sharing partners they may have been exposed to HIV. LINCS staff offer testing to these partners. If they test negative, LINCS staff work with them on primary prevention efforts to support them to stay negative. If they test positive, a LINCS staff member works with them at the secondary prevention level, offering assistance with linkage to care and partner services.

Summary

San Francisco's approach to improving outcomes along the prevention, care, and treatment cascade (figure 2) is a high-impact prevention approach,[26] combining scalable interventions (interventions or combinations of interventions that can reach a significant portion of those in need, in a cost-efficient manner, and demonstrate population-level impact) and effective primary, secondary, and tertiary prevention activities. This approach will allow us to implement the optimal combination of biomedical, behavioral, and structural activities to maximally reduce new infections and meet our local goal (to reduce new HIV infections by 50% by 2017) and the goals of the NHAS (to reduce new HIV infections; increase access to care and improve health outcomes for people living with HIV; and reduce HIV-related health disparities).[8] The Strategy represents a structural approach to HIV prevention, changing the environment in which people at risk for and living with HIV live, work, and play. Secondary and tertiary prevention activities for HIV-positive people are primary prevention for HIV-negative people, even those HIV-negative individuals who never come into direct contact with any other HIV prevention effort.

Gaps and Needs in HIV Prevention, Care, & Treatment

Resources for HIV services are limited. Given this, and the benefits of utilizing a structural, high-impact HIV prevention model, services focus on populations with the highest HIV prevalence. Creative approaches to identifying and addressing gaps must be developed. Epidemiologic data plays a key role in prioritizing resources where they will have the most impact. Community needs and values also continue to have an essential influence.

To understand the gaps in HIV prevention, care, and treatment in San Francisco we must examine who is and is not reached by primary, secondary, and tertiary prevention efforts. We must listen to the voice of communities affected and infected by HIV, and develop strategies to ensure the best services reach the prioritized populations. We must also promote individual and population health using the prioritized interventions. Our approach must continually identify and address gaps along the Cascade; consider the needs of the communities and populations most impacted by HIV; and address structural challenges to preventing HIV.

The gaps and needs identified below informed the development of the Strategy. The roll out of San Francisco's HIV Prevention Strategy began in late 2011, with the funding of services through the HIV Prevention Section (HPS) Request for Proposals (RFP). It is still too soon to thoroughly assess existing gaps and needs. A formal gaps analysis will be part of the SFDPH's ongoing process to ensure appropriate HIV prevention service provision for the populations most impacted by HIV in San Francisco. We will modify our approach over time, as needed.

San Francisco's gaps and needs in HIV prevention, care, and treatment are presented in four categories:

- Gaps Along the Cascade: A Quantitative Perspective
- Community Needs: A Qualitative Perspective
- Populations with Significant Barriers to HIV Testing, Care, and Treatment
- Structural Change Needs

Gaps Along the Cascade: A Quantitative Perspective

The Testing Gap

It is estimated that approximately 15% of people living with HIV (2,740 individuals) in San Francisco are unaware of their status.[27] The SFDPH recommends that all individuals 13 years of age and over test at least once in clinical settings and that MSM, IDU, and TFSM test for HIV at least every six months (see Appendix II, SFDPH's "Guidelines for Routine HIV Screening and Testing According to Setting"). Given these recommendations, it is estimated that there is an annual citywide testing gap of approximately 70,000 tests per year among MSM, IDU, and TFSM (estimate based on NHBS 2005 and 2008 data on self-reported HIV testing in the prior 6 and 12 months), above and beyond current community- and clinically based efforts. The

SFDPH is attempting to bridge this gap by increasing targeted testing in community-based venues, marketing the message of the need to test every six months, strengthening partner services efforts, and supporting SFDPH primary care clinics and other medical settings to increase routine testing.

Gaps in Treatment Access, Engagement, and Retention in Care

The Cascade (figure 1) illustrates that in San Francisco a high percentage, nearly 90%, of people diagnosed with HIV are linked to care. However, the Cascade reveals significant gaps in continuous engagement and retention in care. Of the 862 individuals diagnosed with HIV in 2009 and 2010, 63% remained in care for three to six months, 50% remained in care for seven to twelve months, and 50% achieved viral suppression. The SFDPH, working with community partners, is strengthening efforts to retain people living with HIV in care and treatment services in order to improve individual health outcomes and reduce HIV transmission.

Community Viral Load

Viral load is an indicator of access to care and treatment. Researchers hypothesize that population-level viral burden, or community viral load (CVL), is directly related to the magnitude of transmission in the community, and that viral suppression or decreases in CVL at the population level will be associated with reductions in new HIV infections.

> Community viral load is defined as an aggregate population-level biomarker of a community's viral burden over a specific time period, and represents (1) an indicator of a community's level of transmission probability; (2) a measure of the effectiveness of combination HIV prevention, care, and treatment interventions; and (3) a proximal marker for HIV incidence and potential patterns of new infections.

Total CVL is a measure of viral burden in a particular population, in other words, how much virus is present in a population. Mean CVL, on the other hand, represents the average viral load of everyone in the identified population. Mean CVL is, therefore, a measure that can reveal disparities in particular populations, and indicates challenges related to care and treatment access and utilization. Both are important for HIV prevention, and provide useful information that can be used to prioritize services and resources.

Community viral load is not a perfect measure. In San Francisco, CVL is calculated using the HIV/AIDS case registry. Thus, the accuracy of the CVL estimate is affected by testing efforts, as well as timeliness and completeness of HIV case reporting and the fact that the HIV case registry contains only the information from those individuals who have been diagnosed and consistently reported to the SFDPH. Although use of CVL data has its limitations, the SFDPH will follow CVL trends over time, along with other surveillance and epidemiologic analyses, to assist us in identifying treatment gaps and making decisions about the effectiveness of our current strategy.

The current CVL data suggests that to prevent the greatest number of new infections, the SFDPH should prioritize HIV prevention services in the Castro, an area with the greatest total CVL and a large population of MSM (figure 4). In addition, the data suggests that in order to address gaps and inequalities in access to care and prevention services, the SFDPH should prioritize services in neighborhoods like Bayview/Hunter's Point and the Tenderloin, and services for Latinos, African Americans, and TFSM, to decrease disparities in HIV incidence in the geographic areas and among the sub-populations with the highest mean CVL (figure 5).[5]

Figure 4.

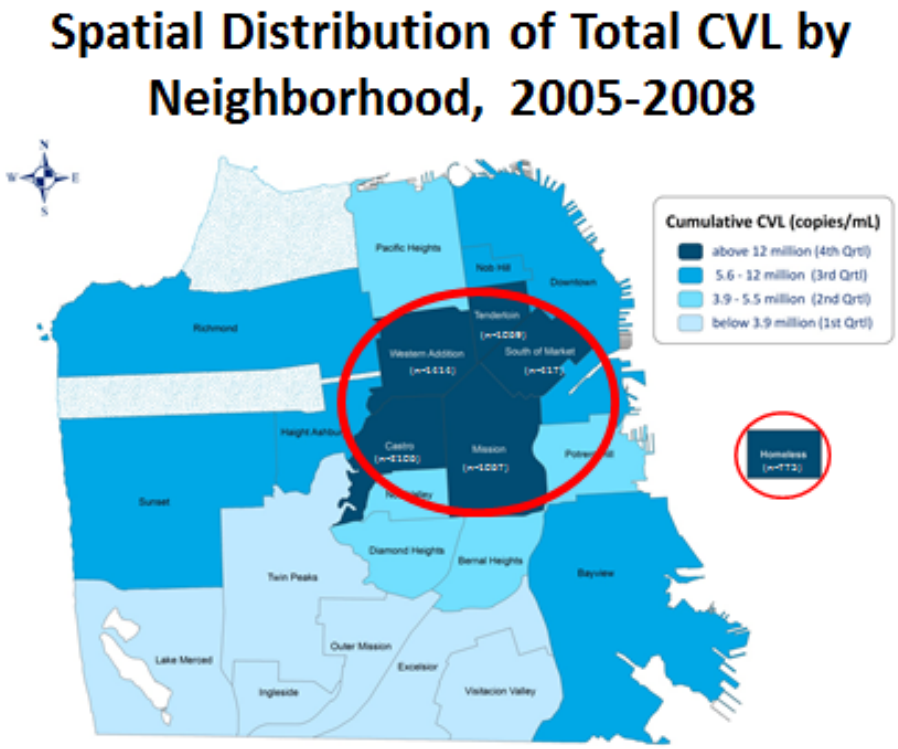
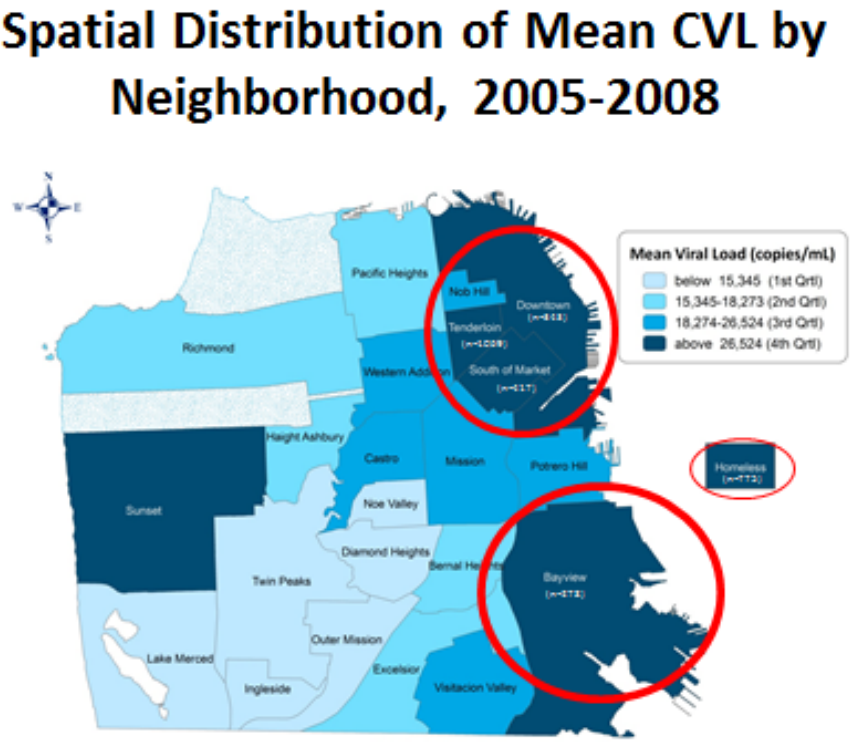


Figure 5.



Community Needs: A Qualitative Perspective

San Francisco is fortunate to have a wealth of high-quality assessments and research on the needs of people living with and at risk for HIV. Over the last few years, numerous needs assessments have been sponsored by SFDPH, the HPPC, and the HIV Health Services Planning Council (HHSPC), the community planning group for HIV health services. These assessments have documented HIV risk, needs, and barriers to HIV testing, care, and treatment identified by various populations. Many of the assessments are thoroughly detailed in the Community Assessment chapter of the *2010 San Francisco HIV Prevention Plan* and are not repeated here. (see Appendix I for a list of assessments)

Collectively, these assessments point to a need for the San Francisco HIV Prevention Strategy to address the following barriers to prevention, care, and treatment:

- Resource issues (e.g., transportation)
- Behavioral health issues (e.g., substance use, mental health)
- Competing priorities (e.g., meeting basic needs, such as housing and food)
- Lack of culturally competent or appropriate services and difficulty understanding health information
- Lack of information/awareness about HIV-related services
- Stigma
- High-threshold services (e.g., inaccessible service hours, locations, restrictive policies for those exhibiting behavioral health issues, waitlists, need to see different providers/specialists for different health issues in various locations).[9]

Given recent reductions in resources and the focus of our new San Francisco HIV Prevention Strategy, some long-standing agencies and programs have closed or merged. These agencies and programs were part of the rich culture of San Francisco nonprofit organizations with unique ties to the communities they served and special relationships with clients. They provided HIV prevention services within a much broader framework of community-building, health promotion, and social support services. The HPPC, HIV prevention providers, and other community stakeholders have identified a gap in the social safety net for gay men, given the reduction in programs focusing on community building and broader health and social issues.

An ongoing dialogue continues among the SFDPH, the HPPC, and other community stakeholders about how best to address the gap in the social safety net for gay men. While these agencies and programs cannot be replaced, the SFDPH has worked and will continue to work to fill resultant gaps, ensure service provision to the priority populations, and build the capacity and cultural competency of funded organizations to effectively provide services to these populations. In addition, public/private partnerships may offer an opportunity to fill this gap through foundation resources that support community-building, broader health promotion, and social support activities. Maintaining HIV-related services for all populations in San Francisco is not possible. However, the structural approach of the San Francisco HIV Prevention Strategy, in which HIV risk is reduced at the community level, will reduce HIV

among all populations, whether directly addressed by services or not. This is precisely the benefit of high-impact prevention—it reaches even those who do not access services.

Populations with Significant Barriers to HIV Testing, Care, and Treatment

As previously explained, it is too early in the San Francisco HIV Prevention Strategy implementation process to formally identify gaps in populations served. However, based on the above data, it is possible to define which populations experience the most significant challenges accessing needed services and/or have the greatest disparities in health outcomes. The data from the previous two sections, as well as other epidemiologic and qualitative data, highlight certain populations as having unmet needs related to diagnosis, care, treatment, and/or health outcomes.

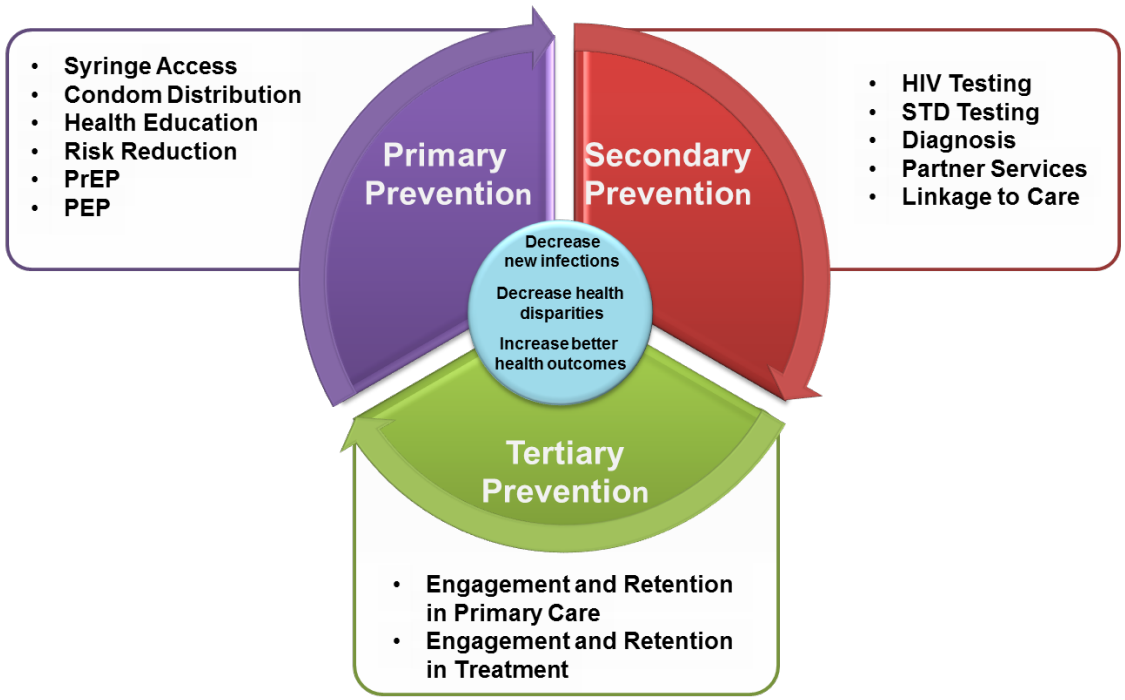
It is noteworthy that so many of the factors that are markers of unmet need center around the social determinants of health. Analysis of factors that prevent engagement to care and treatment among San Franciscans living with HIV reveals that "[s]ocial determinants of health… [are] associated with disparities in engagement in HIV care."[28] The groups less likely to be engaged in care within six months after diagnosis are MSM who inject drugs, persons with no health insurance, individuals with unknown transmission risk, and individuals with unknown housing status. Individuals with unknown insurance status are less likely to be retained in care three to six months after diagnosis. Similarly, the groups less likely to be virally suppressed within twelve months of diagnosis are individuals in younger age groups, MSM who inject drugs, persons with unknown transmission risk, persons with no health insurance or unknown insurance status, and homeless individuals and those with unknown housing status.

The HIV Health Services Planning Council identified six populations that face evolving needs for specialized HIV care:

- MSM, particularly MSM of color
- Persons with HIV 50 years of age and older
- African Americans
- Latinos
- Homeless individuals
- Transgender females

For more information on these populations refer to the *HIV Health Services Comprehensive EMA Plan, 2012*.

San Francisco's Approach to Maximizing the Continuum of Prevention, Care and Treatment



As a highly diverse and complex region with an expanding HIV caseload, San Francisco is home to many populations with significant needs for and barriers to HIV care and treatment. These groups require specialized interventions to link and retain them in care; meet their service needs; and empower them to become effective self-care advocates. The most disenfranchised populations have the most barriers to accessing services and remaining in care. The Ryan White planning process, undertaken by the HHSPC, illuminated these barriers and the populations facing the most significant barriers (see the text box above).29 Effectively meeting the needs of these populations in the context of declining resources remains one of the most daunting challenging issues facing the local system of care.

The table below summarizes data from various sources and assessments, revealing much agreement across assessments regarding gaps and which populations we need to reach.

Data Source	2011 HIV/AIDS Epidemiology Annual Report	CVL assessment	HPPC assessments	HHSPC assessments
Populations by social determinants of health	▪ Persons without health insurance or unknown insurance status ▪ Homeless individuals or individuals with unknown housing status	▪ Homeless individuals ▪ PLWHA who are not engaged in care ▪ PLWHA who are not taking treatment	▪ Late testers/people with unknown HIV status ▪ People with behavioral health (substance use and/or mental health) concerns	▪ Homeless individuals ▪ People with behavioral health (substance use and/or mental health) concerns ▪ People with a lack of information/

			▪ Homeless individuals ▪ People with a lack of information/awareness about HIV-related services	awareness about HIV-related services
Populations by demographics	▪ Younger age groups	▪ Latinos ▪ African Americans ▪ Transgender females	▪ White MSM ▪ Latino MSM ▪ African American MSM	▪ MSM of color ▪ Persons with HIV 50 years of age and older ▪ Latinos ▪ African Americans ▪ Transgender females
Populations by behavioral risk	▪ MSM-IDU ▪ Persons with unknown transmission risk	▪ IDU ▪ MSM-IDU	▪ MSM ▪ IDU ▪ TFSM	
Populations by neighborhood		▪ Bayview/Hunter's Point ▪ The Castro ▪ The Mission ▪ South of Market ▪ The Tenderloin		

Structural Change Needs

Structural issues exist that present significant challenges to HIV prevention in San Francisco. Some of these issues can be addressed by the SFDPH, such as siloed data systems that impact our ability to analyze HIV prevention, care, and treatment data in order to identify service gaps and needs. Other structural issues cannot be addressed solely at the local level. The stigmatization and criminalization of substance use and sex work make it difficult for individuals to talk openly with service providers about behaviors that may put them at risk for acquiring or transmitting HIV. Homophobia, transphobia, and racism all impact individuals' ability to navigate sexual and substance use behaviors and practice HIV prevention techniques.

Social Determinants of Health

The social determinants of health, which are impacted by stigma, race, ethnicity, gender, and sexual orientation, are difficult to address at the local level. San Francisco supports the efforts of the NHAS to put HIV in the context of larger social issues and conditions and to work across the federal government to address HIV holistically. Locally, the SFDPH is working on efforts to integrate HIV prevention, care, and treatment services in behavioral health programs, primary

care services, jails, schools, housing programs, and other services to meet the needs of individuals at risk for and living with HIV and to increase access. These efforts are described in detail in the "Strategies to Address HIV Prevention, Care, and Treatment" section of the document, beginning on page 34.

Integrated Data Systems

Current SFDPH data systems lead to missed opportunities for HIV prevention because systems do not "talk to each other" and are siloed by disease categories and function. SFDPH has made great strides in recent years to make better use of the data we have, by developing collaborations across sections and divisions. For example, linkage to care for individuals testing HIV-positive at community-based sites can now be verified with HIV surveillance data, which is an improvement over the previous method of self-report.

To continue along the path to greater integration, using Centers for Disease Control & Prevention (CDC) funds (PS 12-1201, Part C Demonstration Project), San Francisco is developing a comprehensive integrated data and quality improvement system that incorporates surveillance, public health action, programmatic, and treatment activities. This is one example of many efforts underway in the SFDPH to integrate data.

Although HIV outcomes are clearly emphasized in the demonstration project, the SFDPH is leveraging several funding sources to develop a system for all communicable diseases. The Augmenting High-Impact Prevention (A-HIP) data system will strengthen San Francisco's continuum of prevention, care, and treatment. The A-HIP project will do this by creating a unified system to identify and monitor disease trends, and, if needed, conduct public health action. This system will be developed and implemented over the next few years.

In order for such a system to work, it must contain the names of patients and clients. In Spring 2011, the HPPC's "Project STOREE" (San Francisco Tells Our Real Experience through Evaluation) Committee underwent a process to gather community input and developed strong recommendations regarding how such a names-based system should operate. The committee reviewed current HIV prevention data systems and gathered responses from 225 community members to an online survey that asked for input about current experiences using HIV prevention services and about possible changes to the documentation of services. These responses were interpreted keeping several limitations in mind, including participant biases due to recruitment through provider networks and the frequency in which HIV prevention services were received.

Although this was not a research study, the data provides helpful insight into the reactions community members may have to sharing their names when accessing HIV prevention services. In addition to reviewing these materials, Project STOREE Committee members reflected on their experiences working on local HIV prevention intervention efforts with diverse communities. The Committee developed numerous recommendations regarding the system, which are outlined in the "Project STOREE Committee Updates & Recommendations" report,

prepared in October 2011,[30] and summarized briefly below:

- Explain how such a system will benefit providers and improve client health outcomes.
- Tailor educational messages about the purpose and goals of the system to specific communities and their concerns.
- Clarify what data will be collected, stored, and shared between different organizations.
- Provide a data "report card" presented from a strengths-based perspective (e.g., health protective behaviors) to promote the health of communities.
- Review code-based systems to understand the challenges and opportunities associated with linking individual health information and to prevent possible duplication.
- Ensure client confidentiality through the system.

Resources for HIV Prevention, Care, & Treatment Services

Prior to the release of the NHAS, San Francisco began to move toward the provision of an integrated continuum of HIV-related services to address HIV prevention at the primary, secondary, and tertiary levels. This approach is reflected in the HPS RFP and subsequent establishment of community-based services, and in the operation of the LINCS program, which are discussed in detail in the "Strategies to Address HIV Prevention, Care, and Treatment" section of the document, beginning on page 34.

The SFDPH leverages various resources to support a continuum of HIV services. The San Francisco HIV Prevention Strategy relies on numerous resources, as shown in the table below.

Federal grants	
▪ CDC	▪ Comprehensive HIV Prevention Programs for Health Departments Parts A, B & C (PS 12-1201) ▪ Enhanced Comprehensive HIV Prevention Planning (ECHPP) ▪ Program Collaboration & Service Integration
▪ Department of Housing & Urban Development	▪ Housing Opportunities for People With AIDS (HOPWA)
▪ Health Resources & Services Administration (HRSA)	▪ Ryan White Part A, Part A – Minority AIDS Initiative ▪ Ryan White Parts C, D, F ▪ Special Projects of National Significance (SPNS)
▪ Substance Abuse & Mental Health Services Administration (SAMHSA)	▪ Minority AIDS Initiative – Targeted Capacity Expansion (MAI-TCE) ▪ Substance Abuse Prevention & Treatment Block Grant, HIV Early Intervention Services (a.k.a., HIV Set-Aside)
State grants	
▪ California Department of Public Health (CDPH), Office of AIDS	▪ Ryan White Part B, Part B – Minority AIDS Initiative
Other	
▪ San Francisco General Fund ▪ Private (e.g., foundations, private health insurers) ▪ Third-party payment (e.g., AIDS Drug Assistance Program, Medi-Cal)	

HIV Prevention Allocation

This section focuses on the allocation of resources administered by the SFDPH HPS. Future versions of this document will attempt to describe the broader set of resources that support the Strategy beyond the funding administered by the HPS. The HPS allocates approximately $15.9 million (FY 2011-2012) to support HIV prevention efforts in San Francisco. Programmatic activities and resources are allocated to the most disproportionately affected populations and those that bear the greatest burden of HIV in San Francisco, including populations at greatest risk of HIV transmission and acquisition (see the table below). Those populations include MSM (with particular attention to Latino and African American MSM), IDU, and TFSM (figures 6 & 7)[†]. With the release of the HPS RFP, the SFDPH made allocations based on intervention/activity type designed to reach the three highest prevalence populations in San Francisco.

	MSM	IDU	TFSM	TOTAL
"At-risk" population, 2010[31]	72%	18%	2%	92%
Incidence estimate, 2011[27]	88%	5%	4%	97%
New diagnoses, 2011[2]	82%	6%	2%	90%
PLWHA, 2011[2]	88%	7%	2%	97%

[†] *Figure 6 represents the SFDPH HPS resources allocated for HIV prevention administration and provision of services using CDC funding (PS 12-1201 Parts A & B) and San Francisco General Fund support. Figure 6 does not represent HIV prevention-related research grants or CDC funding that the SFDPH utilizes for the A-HIP Project to develop an integrated database system (PS 12-1201 Part C). The SFDPH utilizes additional resources for HIV prevention activities, such as SAMHSA and HRSA funds. These resources are not reflected.*

Figure 6.

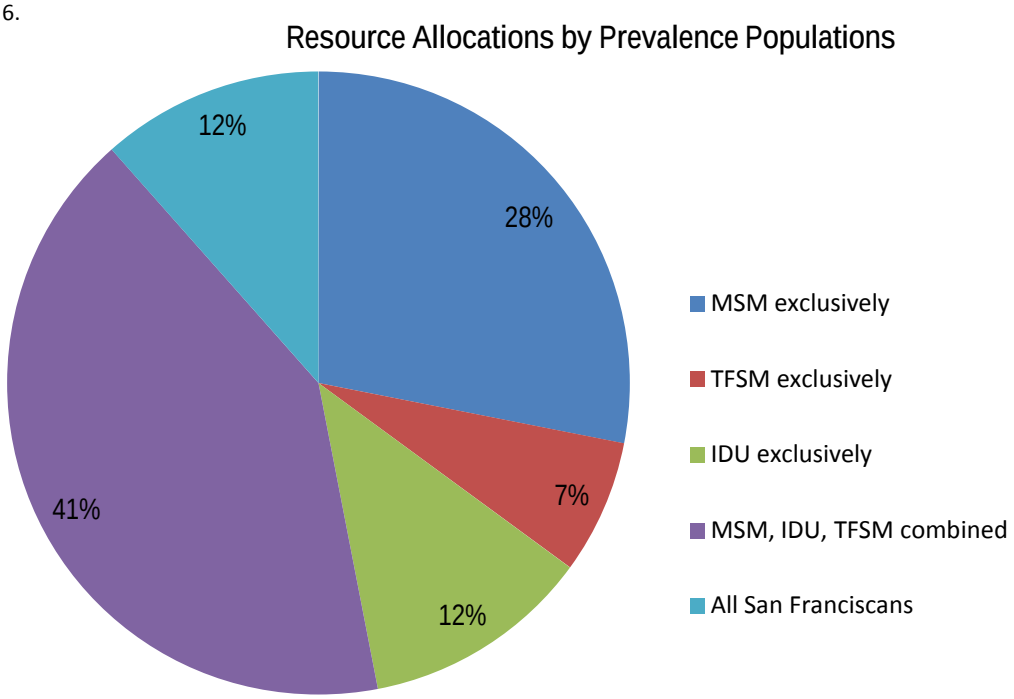
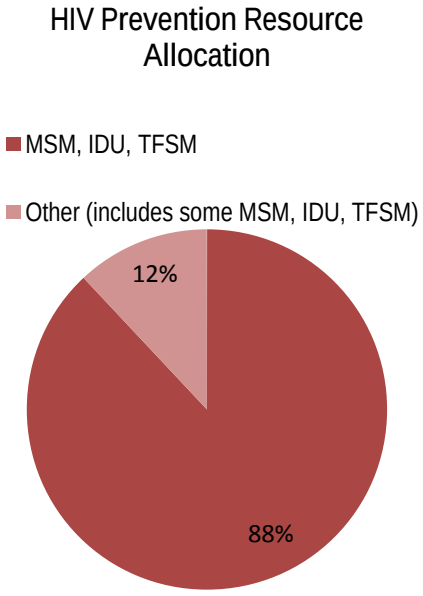


Figure 7.



Resources Allocated for MSM Exclusively:
Resources allocated exclusively for MSM include funds for three of the special "Programs to Address HIV-Related Health Disparities," programs for MSM, Latino MSM, and African American MSM. More information about these programs may be found on pages 56-57. In addition, resources support a program for Asian and Pacific Islander MSM. More information about this program may be found on page 54.

Resources Allocated for IDU Exclusively:
Resources allocated exclusively for IDU include funds for Syringe Access & Disposal. More information about Syringe Access & Disposal may be found on page 39.

Resources Allocated for TFSM Exclusively:
Resources allocated exclusively for TFSM include funds for the special "Program to Address HIV-Related Health Disparities among TFSM." In addition, resources support a wrap-around drop-in service center for all transgender individuals, including TFSM. More information about these programs may be found on pages 57-58.

Resources Allocated for MSM, IDU, and TFSM Combined:

Nearly 90% of the HPS's funding supports services programs that serve MSM, TFSM, and IDU (figure 7). The resources allocated to "MSM, IDU, TFSM combined" includes community-based HIV testing services (see pages 41-46) and PWP services (see pages 47-51). These services largely reach MSM, as evidenced by data from community-based programs from the first half of 2012, which indicates that over 70% of clients accessing HIV testing and over 87% of clients accessing PWP services identified as MSM.

Resources Allocated for All San Franciscans:

The 12% of funding allocated for all San Franciscans promotes testing in medical settings (see pages 41-46) and the efforts of the LINCS program (see pages 48-49). These services reach MSM, IDU, and TFSM, as well as other San Franciscans, accessing medical care in SFDPH clinics and those testing HIV positive who are in need of linkage and retention support. Although the HPS no longer funds community-based services for non-IDU females who have sex with males and/or females and males who have sex exclusively with females, testing in medical settings and the LINCS program provide the most critical services for these populations.

For more information on contractors & subcontractors, a short summary of services they provide, and the funding sources supporting their services, see Appendix VI.

Consolidating and Coordinating Resources

Consolidating Resources

In the current constrained budgetary environment, the SFDPH has made a concerted effort to consolidate resources and services.[32] Through the last HPS RFP, the SFDPH encouraged community-based organizations (CBOs) to submit collaborative proposals with one agency acting as the administrative agent in order to combine back office functions and reduce administrative costs. The SFDPH supports bulk purchasing strategies to reduce costs (e.g., the SFDPH orders condoms and lubricants directly and provides them to numerous nonprofit organizations throughout the city; one contractor orders all syringe access and disposal supplies for the programs engaged in this activity). In addition, the SFDPH supports nonprofits during mergers and closures to ensure service gaps are not created and clients have seamless access to services.

In addition to consolidating resources and services, the SDFPH has increased support for efforts that are scalable and evidence-based, such as HIV status awareness (e.g., testing and partner services), linkage to care, and syringe access. Efforts that are not scalable, such as behavioral interventions, have been streamlined and reduced to focus on individuals in the

high-prevalence populations who engage in behaviors that put them at significant risk for acquiring or transmitting HIV.

The Mayor of the City and County of San Francisco, with support from the Board of Supervisors, allocated General Fund support for two years to partially backfill cuts in CDC and other federal funding, which prevented anticipated cuts to community prevention, care and treatment programs in 2012. These funds have ensured that HIV prevention, care, and treatment programs continue. The SFDPH will work with the community to plan for reductions to programs in the future, likely in fiscal year 2013-2014. Any cuts to services will be made with careful consideration as to the populations most impacted by HIV and to avoid service gaps wherever possible.

Coordinating Resources

The HPS is increasing coordination with HIV Health Services (HHS) to maximize HIV-related resources. Leadership from both sections meets on a regular basis. Efforts are underway to coordinate data reports in line with the Institute of Medicine's indicators for HIV care.[33] We anticipate budget reductions to both the HPS and HHS sections of SFDPH. Working together we will be able to prioritize services and maximize our efficacy toward achieving the shared goals of reducing new HIV infections; increasing access to care and improving health outcomes for people living with HIV; and reducing HIV-related health disparities. For more information about the resources administered by HHS refer to the Resource Inventory in the *San Francisco EMA Comprehensive HIV Services Plan, 2012-2014*, submitted to the U.S. Department of Health & Human Services, Health Resources and Services Administration.

In addition to coordination across HIV prevention and care, San Francisco's Program Collaboration and Service Integration (PCSI) initiative attempts to maximize the impact of resources devoted to HIV, STD, tuberculosis, and viral hepatitis through greater collaboration among the SFDPH sections that focus on these communicable diseases. To date, the PCSI effort has produced integrated screening guidelines and integrated data security and confidentiality guidelines. Plans for the future include the implementation of the integrated data systems funded under PS12-1201 Part C (see pages 26-27) and SFDPH organizational realignment to foster stronger integration. The overall goals are to improve the client experience and improve health outcomes.

The private sector has a role to support HIV prevention efforts in San Francisco by funding CBOs directly to achieve the goals of the San Francisco HIV Prevention Strategy. Private funders can help to fill gaps where the SFDPH's resources are lacking, for example by supporting social safety net services for MSM. In the next year, the SFDPH will engage the private sector, particularly foundations, to ensure they know about the Strategy and local HIV priorities so they may grant-make accordingly.

Health Care Reform

The *Affordable Care Act* (ACA) presents numerous opportunities and challenges for addressing HIV prevention, care, and treatment in San Francisco.[34] The SFDPH has been planning for implementation of the ACA's provisions in collaboration with numerous stakeholders, including the San Francisco HIV Health Care Reform Task Force. The Task Force was requested by the HIV/AIDS Providers Network and the HHSPC in 2011.

Both the State of California and the City and County of San Francisco have taken significant strides toward implementation of the ACA. The city's groundbreaking San Francisco Health Plan, founded in 2009, is a licensed, city-sponsored community health plan that provides affordable health care coverage to over 70,000 low and moderate-income families. Members have access to a full spectrum of medical services including preventive care, specialty care, hospitalization, prescription drugs, and family planning services. Members choose from over 2,300 primary care providers and specialists, six hospitals, and 200 pharmacies, all in neighborhoods close to where they live. The Health Plan has been extremely supportive of SFDPH efforts to increase routine HIV testing, improve the quality of HIV care, and ensure that HIV is addressed with the same level of excellence as other chronic illnesses. This program is complemented by Healthy San Francisco, another city program that makes health care services accessible and affordable for uninsured residents. This is done through the placement of clients in medical homes and with an emphasis on a wellness model of care. Healthy San Francisco has been working with the HPS to ensure clients engaged in HIV prevention services, know about the program and that individuals enrolled in Healthy San Francisco receive HIV testing as a routine part of their medical care. All city-funded health centers are moving toward medical home status, giving them access to expanded city and state healthcare reimbursement support.

These efforts have more recently been augmented at the state level by creation of the Low-Income Health Program (LIHP), California's first step toward implementing health care reform. Also known as "California's Bridge to Reform" and established through the Section 1115 Medicaid Demonstration Program, the program expands Medicaid eligibility for low-income persons living at up to 200% of Federal Poverty Level in 25 of California's 58 counties. The LIHP demonstration project will give California a major head start in enrolling populations in Medicaid prior to the implementation of the ACA. These efforts are being complemented by the State's Medi-Cal Managed Care Expansion Program, which is expanding enrollment of up to 800,000 Medicaid eligible individuals, including persons with HIV, in Medicaid managed care programs.

A related initiative called the Delivery System Reform Incentive Pool (DSRIP) HIV Incentive Program provides federal reimbursement to public medical settings for 50% of costs if certain clinical outcomes are achieved. San Francisco is in the process of assembling baseline data and targets in order to participate in this program. If successful, this will result in a significant drawdown of federal dollars.

Strategies to Address HIV Prevention, Care, & Treatment

San Francisco's integrated approach to HIV prevention, care, and treatment is the cornerstone of our efforts to reduce new HIV infections by 50% by 2017. Through this approach, we seek to: close the HIV testing gap; achieve reductions in individual and community viral load; support services that are appropriate for, accessible to, and meet the needs of the priority populations; and decrease stigma and discrimination that act as barriers to access and lead to health disparities.

Background

San Francisco has been a leader in utilizing innovative strategies to address HIV since the early days of the pandemic. Over the last five years, San Francisco has continued this leadership by shifting to a high-impact prevention approach, to ensure the provision of scalable and effective primary, secondary, and tertiary prevention services.

The core principles supporting San Francisco's approach to HIV prevention are:

- When people living with HIV know their status, they make healthier and safer decisions for themselves and their partners.
- Access to sterile syringes reduces acquisition and transmission of HIV and other bloodborne pathogens.
- Reducing substance use reduces HIV risk behavior and HIV seroconversion.
- Lower HIV viral loads are associated with lower transmission risk.
- Addressing comorbidities (e.g., viral hepatitis, STDs, and tuberculosis) is important for HIV prevention.
- HIV prevention activities have a greater influence if they take place on not only individual- and community-levels, but also at a system-wide level. This includes modifying laws and policies to achieve a higher level of change that influences the broader context of HIV risk.

2010 SF HIV Prevention Plan, page 173

HIV Prevention Activities

The HPS RFP exemplifies the shift in approach by scaling up particular interventions (e.g., testing, syringe access) and scaling back and focusing on individuals at highest risk for HIV through behavioral interventions (see Appendix III for the HPS RFP). In September 2011, community-based programs successful in the RFP process contracted with the SFDPH to rollout programs in the following categories:

- Category 1: Community-Based HIV Testing
- Category 2: Health Education/Risk Reduction (HERR) to Address Drivers among MSM, with a Focus on Gay Males
- Category 3: PWP
- Category 4: Special Projects to Address HIV-Related Health Disparities Among African American MSM, with a Focus on Gay Males

- Category 5: Special Projects to Address HIV-Related Health Disparities Among Latino MSM, with a Focus on Gay Males
- Category 6: Special Projects to Address HIV-Related Health Disparities Among MSM, with a Focus on Gay Males
- Category 7: Special Projects to Address HIV-Related Health Disparities Among TFSM
- Category 8: Citywide Syringe Program: Access, Disposal, Program Coordination, and Bulk Purchasing

These services are funded mainly with CDC PS12-1201 dollars and San Francisco General Fund. In San Francisco, we are utilizing broader resources, as outlined in the previous "Resources for HIV Prevention, Care, and Treatment Services" section of this document (see pages 28-33), to provide an integrated continuum of HIV-related services.

Care and Treatment Activities

The SFDPH's HHS Section administers a robust system of care for eligible PLWHA, including Ryan White Part A and B funds for the San Francisco Eligible Metropolitan Area (EMA) (i.e., San Francisco, San Mateo, and Marin Counties). HHS works in close partnership with the San Francisco HHSPC, a community planning group that meets monthly to oversee the prioritization, allocation, and effective utilization of Ryan White Part A funds and provide guidance to HHS about the overall HIV service system through client and provider input.

Core services the HHS supports within the SFDPH and through CBOs include:

- HIV consumer advocacy
- HIV Centers of Excellence ("one stop shop" programs similar to medical homes with wraparound services which work to stabilize the lives of multiply diagnosed and severe need populations through neighborhood-based, multi-service centers tailored to the needs of specific cultural, linguistic, and behavioral groups)
- Primary medical care (including the SFDPH's Community Oriented Primary Care clinics and the Positive Health Program at San Francisco General Hospital (SFGH))
- Medical case management
- Non-medical case management
- Mental health services
- Substance use services
- Oral health care
- Home/community-based health services
- Emergency financial services
- Food bank/home-delivered meals
- Legal services
- Client advocacy services
- Outreach services
- AIDS Drug Assistance Program

For more information on HIV care and treatment services supported by HHS, see pages 16-20 of the *San Francisco EMA Comprehensive Services Plan, 2012-2014*.[29]

Service Integration Efforts

In addition to the HPS RFP, other examples of San Francisco's shift in approach include various integration efforts. These integration efforts are part of a larger process that San Francisco's health and social service system is undergoing to ensure an integrated service delivery system, centered around the primary medical home, that is prepared for and has the capacity to serve San Franciscans who are expected to enter the system as a result of the ACA.[35] This integration is intended to increase overall coordination of services, improve client experience, and reduce health disparities. Examples of HIV-related integration efforts are highlighted below.

- **HPS Integration:** In fall 2011, the HPS established a Strategic Integration Unit. This unit is devoted to integrating HIV prevention in other divisions of the SFDPH and overseeing planning efforts to ensure the SFDPH takes advantage of opportunities for service integration.

- **Joint HHS / HPS RFP:** In fall 2011, a joint RFP was issued by the HHS and HPS to solicit PWP services in HIV Centers of Excellence. This is described in greater detail on page 50.

- **PCSI:** Through a CDC grant, SFDPH is engaged in efforts to integrate HIV, STD, tuberculosis, and viral hepatitis efforts within the Population Health Division. These efforts were described previously on page 32.

  In June 2012, the SFDPH finalized data-driven integrated preventative services guidelines for SFDPH clinical sites. Phase two of the process is to incorporate the recommendations into the SFDPH Continuous Quality Improvement (CQI) guidelines to make these services "standard of care."

- **LINCS:** The Linkage, Integration, Navigation, and Comprehensive Services Team involves various collaborators (e.g., HPS; STD Prevention & Control; community-based testing venues; SFDPH primary care clinics) to provide linkage to care, retention, and partner services to individuals living with HIV. LINCS is described in greater detail on pages 48-49.

- **HIV Set-Aside:** San Francisco receives support through SAMHSA's Substance Abuse Prevention & Treatment HIV Early Intervention Block Grant (known as the "HIV Set-Aside"), to provide HIV testing and related services for individuals in substance use treatment programs. These efforts are integrated into our larger efforts to provide

testing in community-based and clinical settings. Testing efforts are described in greater detail on page 41-46.

- **Minority AIDS Initiative – Targeted Capacity Expansion Grant:** In September 2011, SFDPH received funding from SAMHSA as part of their grant program aligned with the Congressional Minority AIDS Initiative and the NHAS. MAI-TCE is a multi-sector collaboration involving multiple SFDPH divisions, including Community Behavioral Health Services (CBHS), Community-Oriented Primary Care (COPC), Community Programs' Research & Evaluation section, STD Prevention & Control, Southeast Health Center, HHS, and the HPS.

  Starting in October 2012, the SFDPH integrated behavioral health services into HIV prevention and care services with support from the MAI-TCE grant. These services incorporate positions for behavioral health specialists (clinical social workers or marriage & family therapists) into specific HIV prevention and care service settings (e.g., HIV Centers of Excellence, City Clinic, Southeast Health Center's Transitions Clinic) and through interventions with HIV-negative MSM (Personalized Cognitive Risk-reduction Counseling[36]) and HIV-positive MSM (Motivational Interviewing) to prevent binge drinking and concomitant HIV-risk behavior.

- **The Young MSM (YMSM) Project:** The SFDPH is working with the San Francisco Unified School District and a contractor funded by CDC's Division of Adolescent & School Health to develop a program to reduce HIV and STD among African American and Latino YMSM ages 13 to 19 through school and community-based partnerships. The Project will increase the number of teen YMSM who are tested and treated for HIV and STD; decrease sexual risk behaviors among teen YMSM; and reduce absenteeism and school drop-out among teen YMSM. Program activities will involve the SFDPH, schools, school-based health centers, and CBOs to:
  - Increase access to HIV/STD testing;
  - Provide HIV education specifically tailored to teen YMSM;
  - Raise awareness of HIV/STD prevention strategies through social marketing;
  - Improve collaboration by facilitating connections between school and community-based existing and potential health, social, and educational services and organizations; and
  - Support policies that facilitate the provision of HIV prevention services and education.

Core Activities

The following narrative focuses on efforts funded by the SFDPH's HPS, except where noted. The rationale for and the purpose of the services in these categories is described, along with additional services funded through various mechanisms outside of the HPS's RFP process. The

interventions are categorized by CDC's "required" and "recommended" HIV prevention interventions for health departments (PS 12-1201), with the following exceptions:

- San Francisco's local excellence, syringe access and disposal programs, which is described first;
- Policy/structural initiatives (a required CDC intervention), which are described for each activity.
- Social marketing initiatives (a recommended CDC intervention), which are described where relevant to particular activities.
- Four special "Programs to Address HIV-Related Health Disparities" to serve four priority populations – MSM, Latino MSM, African American MSM, and TFSM. These programs are described after "Evidence-based interventions for HIV-negative people at highest risk of acquiring HIV". They incorporate HIV testing; comprehensive prevention with HIV-positive individuals; and evidence-based interventions for HIV-negative people at highest risk of acquiring HIV.
- "Addressing Stigma, Discrimination, and Criminalization" describes upstream efforts in San Francisco to address social issues that may impact HIV-negative individuals' vulnerability to acquiring HIV and the health and wellness of PLWHA.

San Francisco's Local Excellence

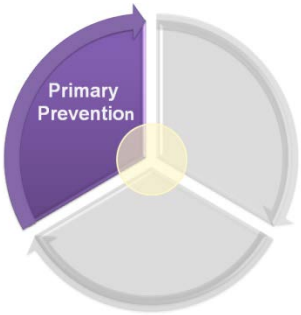
- Syringe access & disposal

CDC's Required Interventions

- HIV testing
- Comprehensive prevention with HIV-positive individuals
- Condom distribution
- Policy Initiatives

CDC's Recommended Interventions

- Evidence-based interventions for HIV-negative people at highest risk of acquiring HIV
- Social marketing, media, and mobilization
- PrEP and nPEP



Syringe Access & Disposal Programs (Local Excellence)

How has it changed?	▪ Scaled up and centrally coordinated
Why?	▪ Proven, cost-effective prevention strategy. ▪ Widely believed that San Francisco's commitment to this harm reduction intervention is responsible for the relatively low incidence of HIV among IDU, as well as the extremely low new infection rates among non-IDU heterosexuals. ▪ Syringe disposal services are also critical, as they facilitate safe disposal of used equipment.
Approach	The program provides two distinct sets of services: 1) Syringe access and disposal services for IDU citywide (direct services to IDU), and 2) Program coordination and bulk purchasing services for subcontractors providing syringe access and disposal services.

Although we cannot utilize federal dollars, the SFDPH is committed to supporting syringe access and disposal services through San Francisco General Fund monies, as syringe access is an essential component of high-impact prevention activities. Program utilization not only provides IDU access to sterile equipment and reduces HIV transmission and acquisition, it also promotes safe disposal of syringes and leads to fewer syringes found on the streets, as compared to cities without syringe access.[37] The SFDPH supports a citywide program with the goal of ensuring that IDU have access to sterile injection equipment to prevent the transmission of HIV and viral hepatitis. These services were funded through the HPS RFP Category 8.

The required syringe access and disposal services include:

- Provision of sterile injection equipment;
- Disposal services for injection equipment;
- Provision of safer sex supplies;
- Education and health promotion;
- Referral to ancillary services; and
- Linkage to HIV testing.

The required program coordination and bulk purchasing services are:

- Order, purchase, and distribute syringes and safer injection equipment for the programs;
- Coordinate data collection for programs;
- Coordinate disposal services for the programs; and
- Manage the SFDPH's syringe disposal kiosks.

The Syringe Access Collaborative, a group with representatives from the various agencies that provides syringe access and disposal services in San Francisco, meets monthly to provide program updates, discuss successes and challenges, and strategize with the SFDPH about issues requiring follow up. In response to the Collaborative's concerns, the SFDPH worked and is working on a number of structural interventions to support syringe access and disposal.

Policy/Structural Initiatives to Support Syringe Access & Disposal

The SFDPH had plans to increase access to syringes by making a policy that all programs funded by the HPS RFP had to provide syringe access and disposal options during the course of their services (e.g., a testing program would make syringes available to IDU clients coming in for testing). This structural intervention was halted due to the reinstatement of the ban barring the use of federal funds for syringe access. We hope to revisit this plan when the ban is lifted again.

Recently, the SFDPH worked with the San Francisco Police Department (SFPD) to renew an existing SFPD bulletin informing officers not to interfere with syringe access and disposal program participants and not to confiscate safer injection and overdose prevention supplies, including naloxone prescriptions, provided by the programs. In addition, the SFDPH worked with the SFPD to develop a training video for cadets and current officers educating them about the programs, laws regarding syringe access, the SFPD bulletin, and safe pat-down procedures to avoid needle-stick injuries. The video was completed in October 2012 and will be shown on a regular basis to cadets at the SFPD Academy and at police "roll call" trainings.[‡]

The SFDPH is also working with the San Francisco Sheriff's Department and the Shelter Monitoring Committee to ensure program participant do not have their program supplies confiscated from their property if arrested or when using shelter services.

In collaboration with a CBO, the SFDPH placed a large, steel syringe disposal kiosk in the organization's parking lot, with access from the sidewalk. This was a successful demonstration effort and the SFDPH seeks to place additional kiosks in areas of San Francisco frequented by IDU in order to provide 24-hour safe syringe disposal access.

In 2007, the Substance Use Issues and Structural Solutions Committee of the HPPC endorsed the creation of a legal supervised injection facility to reduce drug-related harm. Similarly, in 2010, the San Francisco Hepatitis C Task Force recommended to the Mayor to support and fund the creation of a legal supervised injection facility in San Francisco. The creation of such a facility presents significant legal issues. These legal issues, along with the potential public health and cost-benefit of such a facility are issues the SFDPH continues to thoughtfully consider.

[‡] The video may be viewed online at http://youtu.be/_OKVz6k6RgQ.

HIV Testing and Other Status Awareness Efforts (CDC Required Intervention)

How has it changed?	▪ Scaled up
Why?	▪ Approximately 15-20% of San Franciscans living with HIV are unaware of their infection.[3] ▪ Status awareness is good for both individual and community health, because early treatment suppresses viral load and improves health outcomes.
Approach	▪ Expand community-based targeted testing for high-prevalence populations (MSM, IDU, and TFSM) by tripling the number of annual tests provided, for a total of 30,000 tests. ▪ Promote routine, opt-out HIV testing in SFDPH medical settings. ▪ Implement a universal offer of partner services to newly diagnosed individuals.

To reduce new HIV infections, it is critical that people know their HIV status. Studies show that people who know they are HIV-positive reduce their sexual risk behavior.[38] When people have accurate knowledge of their status, they can negotiate safer sex based on real information, not assumptions.

Community-driven prevention strategies, such as seroadaptation (see text box for definition), rely on accurate knowledge of status. Seroadaptation has not been shown to reduce HIV transmission in communities. This is likely due to inaccurate knowledge of status.

Both the HPPC and the SFDPH recommend that all MSM, IDU, and TFSM get an HIV test at least every six months, regardless of HIV risk behavior.

Seroadaptation is an HIV prevention strategy that grew organically in the community. It includes a range of HIV risk reduction practices and refers to the selection of sexual partners, sexual practices, and sexual positioning based on one's own and one's partner's known or assumed serostatus, in order to reduce the risk of contracting and/or transmitting HIV.

This definition of seroadaptation was approved by the Points of Integration committee of the HPPC in 2007.

Community-Based HIV Testing

The SFDPH directly funds community-based HIV testing programs that:

1) Aim to increase frequency of HIV testing among MSM, IDU, and TFSM citywide;
2) Help people living with HIV who are unaware they are HIV-positive learn their status;

3) Support initial linkage to primary care, partner services, and ancillary services for people testing HIV-positive; and
4) Provide people who test HIV-negative with the information, resources, and support to stay negative.

These efforts are supported through a number of mechanisms, including the HPS RFP Category 1, HIV Set-Aside funds, direct funding to organizations from CDC, and direct funding to organizations from private donors.

Routine HIV Testing in Medical Settings

In addition to expanding community-based testing, the SFDPH has prioritized the implementation of the CDC's recommendations for routine testing,[39] using a structural approach designed to detect sporadic cases in people who do not identify themselves to be at risk for HIV or who would not otherwise seek an HIV test.

The SFDPH follows California law, which requires that all pregnant women be offered an HIV test and advised that they have the right to accept or refuse the test.[40] Agreement to test must be documented in the medical record. San Francisco General Hospital adheres to a protocol for rapid HIV testing in the Labor & Delivery Department.

In addition, HIV Set-Aside funds are utilized at four methadone clinics to conduct routine, opt-out HIV testing for individuals accessing opiate replacement therapy.

Partner Services

Although partner services are considered services for HIV-positive individuals to access, their purpose is to increase status awareness. In San Francisco, partner services are bundled with other services for newly diagnosed individuals. The intent of partner services is to reduce HIV transmission by offering an individual living with HIV avenues for informing their sexual and/or needle-sharing partners of possible exposure to HIV, and by providing HIV status awareness interventions and other services to those partners.

Part of partner services is disclosure assistance. For people living with HIV, disclosure assistance includes offering coaching and support for disclosure in a variety of life situations (e.g., family, friends, workplace, etc.). In addition, disclosure of HIV status may help to address the issue of stigma related to having HIV. HIV disclosure and partner services include the following components:

- Help individuals make informed decisions about disclosing their HIV statuses;
- Introduce partner notification options (see options below);
- Help individuals learn to negotiate safer sex whether or not they choose to disclose their status to their partner(s); and

- Provide support and/or referrals to address issues surrounding stigma, shame and fear of disclosure, including fear of violence.

Options for partner notification include:

- *Anonymous third-party notification.* The client gives the service provider names of and/or identifying information about their partner(s). The partner(s) are then notified by SFDPH field staff that they may have been exposed to HIV, without learning the identity of the HIV-positive individual who referred them for this notification. Laws require that anonymous third-party notification can only be conducted by the county health department or a medical provider.
- *Dual-disclosure.* A client discloses his/her status to a partner in the presence of an HIV test counselor who is available to support them both and answer questions. The counselor acts as a facilitator between the client and the partner(s).
- *Self-disclosure.* The provider supports a client to independently tell his/her partner(s) that s/he has HIV, providing skills for disclosure via role playing and other strategies.
- *InSPOT (www.inspot.org).* The client discloses his/her status to partner(s) through email (s/he may remain anonymous) at www.inspot.org. This is also a resource for disclosing STD status to partners.

The SFDPH's routine offer of all partner services, including scaling up the offer of anonymous third-party notification, is a targeted testing approach to ensure the partners of individuals who are living with HIV have been tested and know their HIV status. A description of how San Francisco's partner services are bundled with linkage, engagement, and retention strategies for PLWHA is below in the section on "Comprehensive Prevention with HIV-positive Individuals," on pages 47-51.

Use of HIV Testing Technologies

San Francisco has and continues to utilize innovative approaches to HIV testing, being one of the early adopters of HIV rapid testing in community-based settings. We continue this innovation through efforts to identify individuals in the acute phase of infection, when they have spiked viral loads and may be highly infectious, and efforts to study home test kits.

- **Acute Infection Detection:** The earlier HIV is identified, the more effectively we can curb transmission and prevent new infections. HIV prevention funds support the SFDPH Microbiology Lab in the use of testing technologies to identify individuals in the acute stage of HIV infection. We have supported pooled RNA testing at select community-based testing venues since 2003. In 2011, we expanded screening for acute HIV in the highest prevalence populations (i.e., MSM, IDU, TFSM) at three high-volume testing sites, one of which is the municipal STD clinic, San Francisco City Clinic. In addition, the SFDPH is a partner in CDC's Screening Targeted Populations to Interrupt Ongoing Chains of HIV Transmission with Enhanced Partner Notification (STOP) Study (along with sites in New York City and North Carolina). The STOP Study is comparing the cost-

efficacy of identifying acutely infected individuals utilizing pooled RNA versus 4th generation assay. The Study will also compare the benefit (in terms of new HIV infections detected among partners) of partner services provided to index cases with acute HIV infection and with established HIV infection. Testing for the STOP Study will end in June 2013, with an evaluation year to follow. The results of the STOP Study will inform future efforts to identify acute infections in San Francisco.

- **Home Test Kits:** The SFDPH's Bridge HIV section (formally known as the HIV Research Section) was recently awarded National Institutes of Health funding to develop a home-based HIV self-testing and linkage to care prevention package for young MSM of color, called HOME. HOME is evaluating how home-based HIV self-testing can be used to reach young men of color to increase testing rates and linkage to prevention and treatment services. This study is taking place in Oakland and San Francisco. In its initial stages, the HOME team is surveying providers of treatment and prevention services, and both HIV-positive and HIV-negative men, to build a comprehensive support package to integrate with home self-testing.

Social Marketing to Promote HIV Testing

The following social marketing campaigns did not all receive resources from the SFDPH. They were sponsored by various agencies and created by various advertising companies. They are highlighted here because they are relevant to the San Francisco HIV Prevention Strategy's scale-up of HIV testing.

- **"Greater Than AIDS" Campaign:** The Greater Than AIDS campaign works to reduce HIV-related stigma, particularly in the African American community (www.greaterthan.org) . In June 2012, the SFDPH partnered with San Francisco Pride (the organizers of the San Francisco Lesbian, Gay, Bisexual, Transgender Pride Parade) and Greater Than AIDS to distribute Greater Than AIDS materials, including public service announcements and palm cards. Walgreens provided HIV testing in their Castro pharmacy location during Pride weekend as part of this effort.

- **"Many Shades of Gay" Campaign:** In June 2012, a CBO, with pro bono support from an advertising agency, developed the "Many Shades of Gay" campaign to change social norms among gay and bisexual men regarding HIV testing frequency and to encourage men to test every six months. The website, www.manyshadesofgay.com, allows the user to create an avatar (an electronic image that represents the user), find an HIV testing location, learn information about HIV, and set a reminder to test every six months. The user may set a reminder via text message to receive a discreet message every 6 months or they can link to their Google or Yahoo! calendar directly from the campaign website to set a reminder to get tested. The campaign is promoted with online banners; print and outdoor ads; colorful drink coasters in use at numerous San Francisco bars; and through social media outlets, such as Facebook.

- **"I Vote Yes to Knowing My HIV Status" Advertisement in the San Francisco Voters' Guide:** In the June 2012 San Francisco Voters' Guide, the SFDPH received free ad space to encourage HIV testing among the general population. This opportunity allowed for broad reach to promote the SFDPH recommendation that individuals 13-64 years old test at least once in their lifetime, regardless of risk. The ad encouraged individuals to ask their doctor for an HIV test at their next visit.

- **Most Gay/Bi Men in SF Now Get Tested Every 6 Months" Campaign:** In October 2011, two CBOs collaborated to develop a social marketing campaign that urged gay and bisexual men to test for HIV every six months. The campaign design was "assets-based" in a manner that positively reinforced gay/bi men's existing testing behaviors and set the community norm for testing. Other testing campaigns have been criticized by community stakeholders because they attempted to use fear (of acquiring or transmitting HIV) or shame (about not having been tested or about having unprotected sex) to encourage gay and bisexual men to test more regularly. The campaign was well received.

- **Campaign to Increase Testing in SFDPH Primary Care Clinics:** The SFDPH subcontracted with a local organization to develop a campaign to increase testing in SFDPH primary care clinics. This campaign, in development, will target both clinicians and patients and is aimed at increasing testing among the general population, in accordance with the new SFDPH HIV testing guidelines. This campaign is set to roll out in mid-2013.

- **"HIV Shouldn't Come Between the Two of You" Campaign:** In January 2013, a local CBO launched a campaign to encourage MSM to test with their partners. In tandem with this campaign, the organization has begun providing testing sessions for couples to discuss their concerns about HIV and receive their HIV test results together. The campaign appears in MUNI light rail stations and print ads.

Policy/Structural Initiatives to Support HIV Testing

The SFDPH has undertaken a number of efforts on this front, for example:

- Issuing, in March 2012, "Guidelines for Routine HIV Screening and Testing According to Setting" (see Appendix II). This outlines the jurisdictional policy for providing all San Franciscans with routine HIV screening and testing in healthcare settings and targeted HIV testing in community-based programs for MSM, IDU, and TFSM.
- Developing integrated guidelines for communicable disease screenings (part of PCSI efforts).
- Adding a routine HIV testing measure to the Community Oriented Primary Care CQI measures. The CQI measure states that all SFDPH patients, 13-64 years old, will have at least one lifetime HIV test as documented in the electronic medical record. In the first

year of implementation, the goal is to improve the lifetime HIV testing rate to 60% of active patients and, for clinics that are already above this threshold, to improve lifetime testing by 5% over their current baseline.

- Supporting clinical staff to advocate for increased HIV testing at various SFDPH clinical venues, such as Jail Health Services, Community Oriented Primary Care clinics, and SFGH through changes to policy and practice.
- Developing an agreement with the HIV Epidemiology Section to match testing data with surveillance data to determine which HIV cases identified by testing programs are new cases versus previously known cases so the LINCS program staff can prioritize linkage efforts for individuals newly diagnosed with HIV.
- Establishing a "universal offer of partner services" policy that all individuals identified with HIV are made a direct offer of partner services assistance, including the option of anonymous third-party notification.

Comprehensive Prevention with HIV-positive Individuals (CDC Required Intervention)

How has it changed?	▪ Scaled up
Why?	▪ Viral load suppression is one of many outcomes that can contribute to improved individual health and well-being. ▪ Viral load suppression reduces the potential for HIV transmission to others. ▪ To provide a broader array of services and more closely align the efforts of HIV prevention and HIV care efforts.
Approach	▪ Bundled partner services, linkage to care assistance, and navigation services to engage and retain HIV-positive people in care services, offered through a seamless program to make them more effective and easier for individuals to access. ▪ The ultimate goal of these services is viral load suppression.

The SFDPH and the HPPC have a commitment to support PLWHA to achieve and maintain physical, emotional, mental, and sexual health; economic stability; and well-being.

The SFDPH places a high priority on partner services (described on pages 42-43), linkage to care, and navigation services to engage and retain HIV-positive people in care services. These services are offered in various venues, including:

- SFGH (Positive Health Access to Services and Treatment Team)
- Community-based testing venues (LINCS)
- Primary care settings (LINCS)
- PWP programs in community-based settings
- PWP programs in HIV Centers of Excellence

The SFDPH's exemplary STD partner services program and the PHAST Team are both models that have informed our approach to providing comprehensive partner services, linkage to care, and navigation services. These services are described in below.

Positive Health Access to Services and Treatment (PHAST) Team

Since 2002, the PHAST Team is a rapid response team that has championed HIV testing, linkage to care, and retention and re-engagement in care across the SFGH campus. The mission of the PHAST Team is to identify undiagnosed HIV infection in all patients who have contact with the SFGH system; provide rapid linkage to care for individuals who are newly diagnosed or have barriers to engagement in care; initiate antiretroviral therapy (ART) as soon as possible in all patients who are accepting of treatment; and support vulnerable patients by

providing nursing care coordination and psychosocial stabilization throughout the linkage to care process.

The PHAST team consists of a registered nurse, nurse practitioner and social work associate. This team supports over 500 patients at risk for poor linkage to care and who are primarily persons of color with high rates of homelessness, mental illness and active substance use. The average age of participants is 39 and 11% are under the age of 25. At entry into the PHAST program, 21% of patients are taking ART. Within one year of participation in PHAST, 71% of patients are taking ART and 52% have undetectable HIV viral load. The lost-to-follow-up rate for PHAST patients is <10%. Patients who are lost to follow up are referred to the LINCS team, who utilize additional methods to attempt to locate these individuals.

The LINCS Program

San Francisco has broader needs for linkage and retention services beyond the services the PHAST Team provides at SFGH. Building on the PHAST Team's success and utilizing it as a model, the SFDPH created the Linkage, Integration, Navigation, and Comprehensive Services program. The LINCS program takes best practices from the PHAST Team's model to develop a citywide service that bundles partner services with linkage to care and engagement and retention strategies.

LINCS is a collaborative effort of the SFDPH's HPS and STD Prevention & Control; it partners with the HIV Epidemiology Section for data sharing to improve quality of care and quality of data, and is part of system integration within the SFDPH. The LINCS program is both direct services and a citywide safety net.

Direct services provided by the LINCS program include linkage to care and partner services for newly diagnosed individuals and navigation services for PLWHA who are not fully engaged in primary care.

- *Linkage and Partner Services.* This component of LINCS is managed by STD Prevention & Control. Staff members from this section are detailed to work at high-volume community-based test sites, and work directly with all clients testing newly positive to ensure they are linked to care and have the opportunity to engage in partner services. The LINCS staff members work with each client for up to 90 days to ensure they attend their first medical appointment and have established a solid primary care relationship. For lower-volume test sites, a "rover" is on call to go to the site if there is a reactive test. The rover also serves the SFDPH clinic system.

- *Navigation.* This component of LINCS is managed by the HPS. Eligible individuals are connected to LINCS in one of four ways: 1) primary care or other provider referral; 2) self-referral (individuals learn about LINCS through word-of-mouth or media); 3) from the STD Prevention & Control LINCS staff, if a person has not been linked by 90 days

after diagnosis; or 4) through the Re-engaging Surveillance-identified Viremic Patients (RSVP) project. RSVP is using the electronic HIV surveillance system (eHARS) data for San Francisco to identify HIV cases for follow up. Individuals are tagged for follow up if they have an HIV viral load greater than 200 copies/mL at last measurement and no HIV viral load or CD_4+ cell counts in eHARS during the past 9 to 15 months. RSVP participants are invited for an interview and then offered linkage to care and navigation services through LINCS. LINCS Navigators work with HIV-positive patients intensively for a 90-day period to try to achieve the goals of engaging them in primary medical care for HIV, and connecting them to longer-term case management and other services through warm referrals and direct handoffs. Partner services are also included when appropriate.

In addition to the direct services LINCS provides, the goal is for LINCS to be a citywide safety net for linkage and engagement in care. LINCS is not intended to replace PHAST or any of the other existing linkage and retention efforts for which San Francisco is considered a leader. What is unique about LINCS is that it is a SFDPH program with access to data systems, such as HIV surveillance and the SFDPH electronic medical record, that can help identify and locate individuals in need of services who might not otherwise be noticed. In other words, the program has the ability to catch the people who are "falling through the cracks."

The other important and unique quality of LINCS is that it includes partner services as an integral component. By pairing linkage and navigation with partner services, HIV-positive individuals have the opportunity to get support to disclose their HIV status and/or take advantage of the third-party anonymous notification service. This approach is effective because it allows for the partners of newly diagnosed individuals to learn their HIV status, and if they are positive, access care and treatment early in the course of infection.

Other Linkage and Retention Efforts

The PHAST Team and the LINCS program are not the only linkage and retention efforts in San Francisco. The SFDPH's role is to coordinate all linkage and retention efforts to ensure resources are maximized, fill gaps in services as relevant, and avoid duplication of efforts. Additional efforts include:

> The term **prevention with positives** (PWP) has traditionally been used to refer to services to improve individual health and well-being, with the goal of reducing HIV transmission risk behavior. In San Francisco, PWP refers to a much broader array of services and activities for improving health and well-being, including treatment adherence and engagement in care, with the additional goal of suppressing viral load.

- *PWP (HPS RFP Category 3).* PWP programs are needed for individuals who require ongoing support to adhere to treatment, engage in care, and reduce HIV transmission risk behavior, in order to suppress their viral loads, reduce HIV transmission, and improve their overall health. Such programs can be most

effective when strongly tied to the clinical setting because clients will benefit from their primary care and PWP providers working together to identify and meet their needs.

The SFDPH funds programs for HIV-positive MSM, IDU, and/or TFSM that support individuals to engage in their care so that they can experience the best possible health outcomes and reduce opportunities for HIV transmission. The required program activities are treatment adherence; engagement in HIV care; disclosure assistance; health education/risk reduction to address HIV risk behavior; linkage to ancillary services (to meet client needs and address barriers to adherence, engagement, and risk reduction); and STD, viral hepatitis, and tuberculosis screening and treatment. Programs also include a prevention case management (PCM) component.

Programs must serve one or more of the following populations: HIV-positive MSM, HIV-positive IDU, and/or HIV-positive TFSM at highest risk for HIV transmission, as indicated by the following characteristics (listed from highest to lowest priority):

- Priority 1: Individuals with unsuppressed viral load, regardless of other factors.
- Priority 2: Individuals at risk for unsuppressed viral load (e.g., those with multiple co-morbidities such as substance use, mental health, tuberculosis, and viral hepatitis; those with recent missed primary care appointments; those with less than 95% adherence to their medication regimen)
- Priority 3: Individuals with suppressed viral loads who have indicators of HIV transmission risk behavior (e.g., current STD, reported unprotected sex with HIV-negative or unknown status partners).

Providers may also consider including education about community-driven prevention strategies, such as seroadaptation. The HPPC encourages PWP programs to discuss the potential risks and benefits of seroadaptation as a prevention strategy with clients and integrate discussions regarding risk for STD and viral hepatitis.

PWP services funded through the HPS RFP are supported in two ways: first, as its own service category (i.e., where PWP is the only focus of the program); and second, where it is included as a component of four special "Programs to Address HIV-Related Health Disparities" (these programs are described in greater detail beginning on page 56).

- *PWP Services in the HIV Centers of Excellence.* In addition to funding PWP services through the HPS RFP, the HPS provided $420,000 to SFDPH's HHS to include in its last RFP, to support PWP services at four Ryan White-funded HIV Centers of Excellence (CoEs) (which are one-stop-shops/medical homes for Ryan White-eligible people living with HIV). This collaboration seamlessly links HIV prevention services with HIV care and treatment services for the populations at highest risk for transmitting HIV – individuals with high viral loads who are not engaged in care (particularly MSM, IDU, and TFSM). The CoEs are supported to provide PWP services, in addition to the HIV care and treatment services they provide.

- *Special Projects of National Significance.* The SFDPH's HHS received two HRSA Special Projects of National Significance (SPNS) grants. The Grants focus on linkage of newly diagnosed individuals and retention in care efforts for two populations: transgender women of color and homeless and marginally housed individuals. Both SPNS projects are a collaborative effort of HHS, the SFDPH's Tom Waddell Health Center, and a CBO.

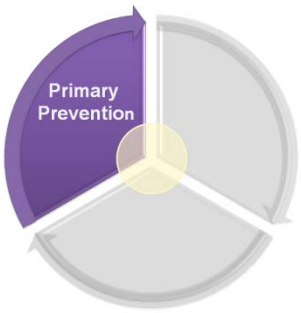
- *Behavioral Health Specialists.* Embedding behavioral health specialists into HIV CoEs, City Clinic, and the Transitions Clinic (a clinic for individuals re-entering the community post-incarceration) offers opportunities to support people living with HIV with substance use and mental health services and assistance with treatment adherence, disclosure issues, and linkage to basic needs services (e.g., housing, food, vocational rehabilitation). These services are supported by the SAMHSA MAI-TCE grant described previously, on page 37.

- *Perinatal Prevention.* In San Francisco no babies have been born with HIV since 2004. The Bay Area Perinatal AIDS Center (BAPAC) at SFGH provides preconception counseling, psychosocial services, and ART for HIV-positive women in San Francisco. BAPAC provides prenatal care to approximately 25-30 HIV-positive women annually and preconception counseling to approximately 200 HIV-positive women annually throughout the San Francisco Bay Area. (BAPAC is not funded under PS12-1201)

Policy/Structural Initiatives to Support Comprehensive Prevention with HIV-positive Individuals

- *PWP Best Practices Guide.* In 2009, the SFDPH developed the *Prevention with Positives: Best Practices Guide*.[41] It offers a "tool kit" of resources and guidelines for providers and program managers working with PLWHA. The creation of the Best Practice Guide involved an innovative approach that brought together the HPS and HHS, resulting in a comprehensive perspective on PWP. Providers, community members and consumers from diverse agencies and backgrounds met monthly to develop and review the content of the guide. In addition, input was gathered through a community forum held toward the end of the process. An extensive review of the existing literature and guidelines on PWP also contributed to the content. This document is the result of ongoing efforts by the HPS and HHS to develop tools for carrying out PWP. This guide will be updated in 2013 and a similar stakeholder process will inform the process.

- *Universal Offer of Treatment Policy.* In January 2010, the SFDPH issued new guidelines recommending "early ART initiation for all motivated patients regardless of CD_4 count or HIV viral load… [and that] all patients should be offered ART unless there is a reason to defer therapy."[42] This structural intervention, to provide early treatment, is critical for achieving reductions in individual and community viral load. Efforts to link and engage PLWHA in care and treatment services include efforts to support newly diagnosed individuals with initiation of ART.



Condom Distribution
(CDC Required Intervention)

How has it changed?	▪ Scaled up
Why?	▪ To ensure individuals at risk for HIV and PLWHA have adequate access to condoms for safer sex.
Approach	▪ Currently, the SFDPH distributes approximately 850,000 condoms per year to approximately 200 venues (including high schools, SFDPH-funded sites, CBOs and other nonprofit organizations). ▪ Condom distribution is managed at approximately 60 of those venues by a CBO. The organization distributes about 50,000 condoms a month. ▪ We aim to double the number of condoms we distribute in San Francisco by expanding the existing condom access program to reach neighborhoods and communities that do not currently have easy access to free condoms and are disproportionately affected by HIV.

Most condoms are distributed in bars, shops, and restaurants in the Castro neighborhood of San Francisco, a neighborhood with a substantial MSM population and MSM-oriented nightlife. In addition, condoms are available at the front desk in the HPS administrative offices, where many individuals from high-prevalence populations check in for participation in research studies.

The SFDPH is in the process of expanding the existing condom access program. Condoms will be distributed via dispensers and fishbowls at a network of bars, shops and other venues. This expanded condom access program will more effectively reach high-prevalence populations (MSM, IDU, TFSM) that live outside of the Castro neighborhood. Specifically, we plan to increase free condom distribution in the Tenderloin, Polk Street corridor, 6th Street corridor, Bayview, and Mission neighborhoods. The SFDPH is working with a contractor to facilitate focus groups with the highest prevalence populations and businesses in these neighborhoods to determine the best distribution strategy. A partner organization in the Bayview neighborhood is surveying youth of color to determine how best to improve their access to condoms and surveys have been conducted with participants in the Tenderloin and Mission neighborhoods, and online. This data is guiding our efforts to ensure we make condoms accessible in venues appropriate for our priority populations and that we address any barriers to access.

Social Marketing to Promote Condom Use

- **"FC2" Campaign:** On February 14, 2011, the SFDPH launched a campaign to promote the FC2, also known as the "female condom," via ads on MUNI buses and trains and through local businesses and CBOs. The SFDPH provided in-service trainings to providers and free FC2s to any venue that had its staff/volunteers take the training. In 2012, a second year of funding was granted to support the development of an interactive, web-based training to reduce staffing needs and provide wider access to FC2 training for providers. The purpose of the campaign is to encourage knowledge of the FC2 and promote its use as a safer sex option for everyone, as it can be used for vaginal and anal sex. Campaign materials feature photographs and text to reach specific communities, including transgender individuals, MSM, and women who have sex with men (www.fc2sf.com).

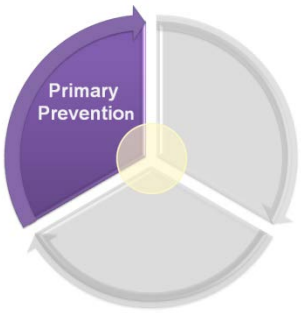
- **Campaign to Promote New Condom Distribution Program:** In late 2013, the SFDPH anticipates developing a campaign associated with the launch of the new condom distribution program to increase interest in free condom access in San Francisco.

Policy/Structural Initiatives to Support Condom Distribution

Condom Access at SFDPH-funded HIV Programs. Through contractual agreement, all SFDPH-funded HIV prevention programs and the Ryan White Centers of Excellence are required to make condoms available to their program participants.

Condom Access in the San Francisco County Jails. The SFDPH's Forensic AIDS Project advocated for structural change to ensure prisoners have access to condoms. Forensic AIDS Project, in collaboration with the San Francisco Sherriff's Department, established and maintains an innovative condom dispenser program in the San Francisco Jails. In 2007, Forensic AIDS Project piloted a condom dispenser program to make condoms more accessible to prisoners through the jails. There are now seventeen condom machines for prisoners to access free condoms while incarcerated. The San Francisco County Jail is one of only a handful of jails/prisons in the United States that makes condoms available to prisoners. San Francisco's program served as a model for a pilot program in one of the State of California prisons.

Addressing the Use of Condoms as Evidence of Solicitation. The SFDPH is working collaboratively with the San Francisco Human Rights Commission, law enforcement officials, and community partners to explore the possibility of condoms not being used as evidence of solicitation and not being confiscated and photographed by police officers.



Evidence-based Interventions for HIV-negative People at Highest Risk of Acquiring HIV (i.e., Health Education and Risk Reduction Programs)
(CDC Recommended Intervention)

How has it changed?	▪ Scaled down
Why?	▪ Evidence-based behavioral interventions, called "health education and risk reduction" (HERR) programs in San Francisco, are an essential part of a combination approach to HIV prevention. ▪ Because they are intensive, behavioral interventions are not scalable. Thus, support for HERR in San Francisco is consolidated to the highest prevalence population.
Approach	▪ Intensive behavioral programs that provide MSM with the skills, tools, and support necessary to reduce the effects of drivers (see below for definition of drivers) in their lives and to increase and maintain safer sex behaviors.

The *2010 San Francisco HIV Prevention Plan* outlines six "drivers"—factors that contribute to a substantial portion of new HIV infections, especially among MSM and MSM who inject drugs. These drivers are crack/cocaine use, heavy alcohol use, methamphetamine (meth) use, poppers use, gonorrhea, and multiple partners (see the text box below and the table on the following page).[9] Because these drivers have been shown to be linked directly and independently to new HIV infections among MSM, programs to reduce these drivers have the potential to prevent new HIV infections in this community.

The HPPC developed the following criteria to help define and identify drivers.

To be a driver of HIV in San Francisco, an issue must meet BOTH of the following criteria:

1. *Have at least 10% prevalence among one of the highest prevalence populations (MSM, IDU, TFSM).*
2. *Be an independent factor for HIV, making a person in a high-prevalence population at least two times more likely to contract HIV compared to someone who is not affected by the driver.*

Overarching factors such as racism, homophobia, poverty, social isolation, and lack of access to health care create an environment in which certain individuals or communities become more prone to experiencing a driver, thus increasing risk for acquiring HIV. While these contextual factors are not proximal enough to the point of HIV infection to be identified as drivers, they must not be overlooked.

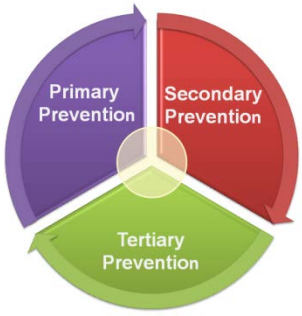
Under the HPS RFP Category 2, the SFDPH supports intensive behavioral programs for individuals in the highest prevalence population in order to reduce the effects of drivers on HIV risk among MSM, regardless of HIV status. Programs are intensive, meaning they engage clients in an ongoing way with individual- and/or group-level

interventions that help build community and change social norms. Behavioral intervention through HERR programs to address drivers is also supported through the HPS RFP Categories 4-7, where it is included as a component of four special "Programs to Address HIV-Related Health Disparities" (these programs are described in greater detail on pages 56-58), and through a program that provides HERR services for Asian and Pacific Islander MSM, including a program specifically for TMSM.

Prevalence of Drivers Among MSM in San Francisco	
Driver	Prevalence of Driver Among MSM in San Francisco
Cocaine and crack use	25% used cocaine in the past 12 months*
Heavy alcohol use	52% had 5 or more drinks in one sitting on at least one occasion in the prior 30 days*
Methamphetamine (meth) use	13% use methamphetamine in the past 12 months*
Poppers	19% used poppers in the past 12 months*
Gonorrhea	14% of a non-random sample of gay/bisexual men had rectal, urethral, and/or pharyngeal gonorrhea**
Multiple partners	58% had more than one sex partner in the past 6 months*
* National HIV Behavioral Surveillance Survey, 2008. **Kent et al 2005. Clin Infect Dis 41(1):67-74.	

Policy/Structural Initiatives to Support HERR Programs

Unlike other efforts, there is no specific policy/structural initiative for HERR. Note that how this activity fits within the larger San Francisco HIV Prevention Strategy is a structural change. We have scaled down behavioral interventions and focused them on addressing drivers with MSM. In addition, linkage to HIV testing is an outcome for HERR, signaling a structural change in our approach to this activity.



Programs to Address HIV-related Health Disparities

How has it changed?	▪ N/A – these are new initiatives
Why?	▪ Four populations experience the greatest HIV-related disparities in San Francisco: o MSM with a focus on gay males o Latino MSM with a focus on gay males o African American MSM with a focus on gay males o TFSM ▪ Prioritizing resources to provide comprehensive HIV prevention services for these communities is critical to addressing disparities and achieving health equity.
Approach	▪ Programs with a holistic approach to HIV prevention, using a combination of services designed to meet the specific needs of the population of focus. ▪ The required services are HIV testing, HERR, PWP, and linkages to appropriate services. ▪ Program goals include: o Promoting status awareness; o Providing information, resources, and support to stay negative; o Supporting initial linkage to primary care, partner services, and ancillary services for individuals who test newly HIV-positive; and o Supporting PLWHA to fully engage in their care.

Programs to address HIV-related health disparities work to change the HIV testing norm among the populations of focus, such that testing at least every six months becomes a regular practice. These programs have a strong focus on HIV risk reduction, including components that address drivers, cofactors, contextual factors, and HIV risk behaviors, particularly unprotected anal sex. The programs incorporate recommendations from the *Latino MSM Action Plan*, the *African American MSM Action Plan*, and other documents as appropriate, in order to meet population needs and achieve program goals. These services were funded through the HPS RFP Categories 4-7.

HIV-Related Health Disparities among MSM

MSM are disproportionately affected by HIV, both in San Francisco and nationwide. In San Francisco, MSM are over 400 times more likely to contract HIV than males who have sex only

with females.[43] This overarching disparity often goes unacknowledged in the efforts to ensure that subgroups of MSM are effectively and appropriately served. In San Francisco, MSM represent 85% of people living with HIV and are estimated to make up 87% of all new HIV infections.[44]

HIV-Related Health Disparities among Latino Males MSM

Latino MSM have a high HIV prevalence, estimated at 19-29%, similar to white MSM. However, data from the 2008 San Francisco arm of the NHBS Survey found that the prevalence of unrecognized HIV infection was 7.8% among Latino MSM compared to 1.5% among white MSM. [44]To identify actions to address the needs of this population, a working group of Latino MSM and their allies developed a *Latino MSM Action Plan*, which was endorsed by the HPPC in September 2009.[45] This process identified a need for specific services reaching Latino MSM.

HIV-Related Health Disparities among African American MSM

Among MSM, African American MSM are disproportionately affected by HIV. HIV prevalence among this group is estimated at 25-40%.[46] One data analysis indicated that a 20-year-old African American MSM in San Francisco has an 80% chance of becoming infected with HIV by the time he is 60 years old (compared to white MSM at under 60%).[46] Although this trend appears to be changing course and all MSM at age 20, regardless of race/ethnicity, now have a similar chance of becoming infected by the age of 51 (approximately 20%), significant disparities related to the number of African American MSM living with HIV,[47] and related to HIV-related morbidity and mortality, will continue in this community.[2] To begin to understand the reasons behind this health inequity, and to identify actions to address the needs of this population, a working group of African American MSM and their allies developed an *African American MSM Action Plan*, which was endorsed by the HPPC in February 2009.[46] This process identified a need for specific services reaching African American MSM.

HIV-Related Health Disparities among TFSM

Of all populations in San Francisco, TFSM are believed to have the highest HIV prevalence and incidence. This gross disparity may be at least partly attributed to gender-based stigma and discrimination, which in turn contributes to HIV cofactors such as substance use, mental health issues, sex work, homelessness, and lack of job opportunities. Although the transfemale population in San Francisco is relatively small (most recently estimated at approximately 1,676), it is believed that nearly 40 percent of transfemales are living with HIV.[48]

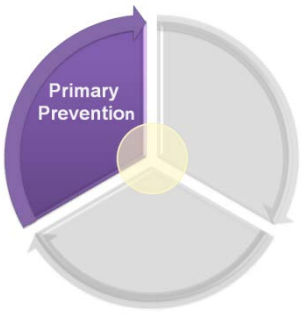
In addition to the project to address HIV-related health disparities among TFSM, the SFDPH supports a wrap-around drop-in service center offering psycho-educational workshops, case-

management, linkage and referrals, and social support services for all transgender clients, including TFSM, to improve their health and well-being and reduce risk for HIV and substance use.

Policy/Structural Initiatives to Address HIV-Related Health Disparities

Unlike other efforts, there is no specific policy/structural initiative for addressing HIV-related health disparities. Ultimately, a goal of this Strategy is to reduce health-related disparities and all the activities that comprise the Strategy are designed to support achievement of this goal.

Our approach to providing programs specifically to reach populations that experience the greatest HIV-related disparities is a structural change – this is the first time the SFDPH and community partners have developed holistic programs that combine HIV testing, PWP, and HERR for priority populations.



Pre-exposure Prophylaxis (PrEP) & Non-occupational Post-exposure Prophylaxis (nPEP) (CDC Recommended Interventions)

How has it changed?	▪ PrEP – launched ▪ nPEP – no change (affirmed the role of nPEP in our Strategy as it continues to be in demand)
Why?	▪ PrEP is a promising approach to preventing HIV infection prior to exposure. ▪ nPEP may prevent an HIV infection from occurring after a possible exposure.
Approach	▪ PrEP Demonstration Project at San Francisco City Clinic to prevent HIV among MSM and TFSM engaged in activity that puts them at risk for acquiring HIV. ▪ nPEP at San Francisco City Clinic for eligible individuals who may have been exposed to HIV to prevent exposure from leading to infection.

PrEP Demonstration Project

The SFDPH has been awarded a grant from the National Institute of Allergy and Infectious Diseases to conduct the first PrEP demonstration project. The project is a collaboration with the University of Miami. In San Francisco, the project will be conducted at San Francisco City Clinic, the city's municipal STD clinic. The enrollment goal is 500 MSM and TFSM; 300 will be enrolled at San Francisco City Clinic and 200 at the downtown STD clinic in Miami, Florida. Enrollment began in September 2012. Participants are offered up to 12 months of Truvada®; regular HIV testing; condoms and risk reduction counseling; STD testing and treatment; hepatitis B vaccination; linkage to other prevention services; counseling support for pill-taking; and blood tests to monitor for safety at each clinic visit. Results from this demonstration project will inform whether and how San Francisco could implement PrEP as a part of our combination prevention strategy. The project seeks to answer the following questions:

- Who wants PrEP?
- How will PrEP be used?
- Does taking PrEP affect the way people have sex?
- Can PrEP be provided through public health clinics?

nPEP

HIV prevention funds support the nPEP program at SFDPH's City Clinic. The nPEP program entails a clinical visit with a doctor or nurse practitioner, an HIV rapid test to determine eligibility, and risk reduction counseling and health education as its related to nPEP. All nPEP patients receive a "PEP packet" containing fact sheets on managing side effects and tips for

taking medications, as well as frequently asked questions and follow-up instructions. City Clinic provides two days of Truvada® as a starter kit for medications, and a prescription for the remaining 26 days, which can be filled at no cost to uninsured patients at the SFGH pharmacy. Insured patients (with private insurance or Medi-Cal) may have copays or other fees to obtain the prescription, per their coverage. A health worker is available to provide telephone-based or in-person support while patients are on nPEP. City Clinic also offers follow-up testing and further risk reduction support upon completion of the nPEP course. High-risk or repeat nPEP clients are linked to City Clinic's Behavioral Health Specialist, supported under the SAMHSA MAI-TCE grant. City Clinic serves as the main referral site for nPEP in San Francisco.

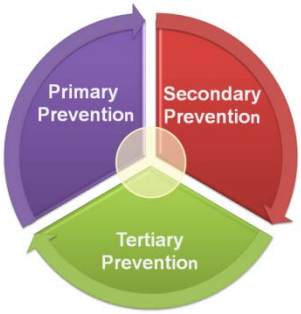
The SFGH's Emergency Department, Urgent Care Clinic, and Rape Treatment Center all provide nPEP services. In addition, nPEP is provided at non-SFDPH medical settings, such as Kaiser Permanente and other hospital emergency departments.

Social Marketing to Promote PrEP

- **"Love May Have Another Protector" Campaign:** In late 2012, a local CBO launched a web-based campaign to provide information about PrEP and the PrEP demonstration project to the community (www.prepfacts.org).

Policy/Structural Initiatives to Support PrEP and nPEP

- The SFDPH is in the process of developing PrEP guidelines and recommendations, which will be forthcoming in 2013.



Addressing Stigma, Discrimination, & Criminalization

Stigma, discrimination, and criminalization related to HIV status, gender identity, sexual orientation, sex work, substance use, mental health, and other factors impacts people's capacity to engage in HIV prevention activities.

The SFDPH works to address a number of these factors through structural interventions, described in the previous narrative and summarized in the text box on this page. A goal of the San Francisco HIV Prevention Strategy is to reduce health-related disparities. All the activities that comprise the Strategy are designed to support achievement of this goal.

The City and County of San Francisco engages in larger policy activities to promote equity and access to services and reduce stigma and discrimination. Two examples are described below.

Examples of SFDPH Structural Interventions

- Working with SFPD on processes to ensure HIV prevention supplies are promoted and not confiscated or used as evidence.
- Normalizing HIV testing by making it routine, and not risk-based, in medical settings.
- Ensuring individualized services are available for people in high prevalence populations (through the programs to address HIV-related disparities and the MAI-TCE project).
- Working with community stakeholders to ensure that the integrated database maintains client confidentiality.

- *Transgender Non-discrimination Policy.* In 1995, San Francisco Administrative Codes and Police Codes were amended to prohibit discrimination based on gender identity in response to a 1994 public hearing held by the Human Rights Commission (HRC). Transgender people are subjected to severe discrimination in employment, housing, and public accommodations and no local, state, or federal law provided protection and no recourse existed when discriminatory actions occurred. Since the law was changed, the HRC continues to receive complaints from people who are not hired, are not promoted, are fired, are denied housing, are denied services, are denied access to facilities, and are discriminated against because of their gender identity. The HRC investigates complaints and provides training and education to businesses and organizations seeking to comply with the law.[49] This non-discrimination policy is critical to HIV prevention for transgender individuals as social determinants of health, such as access to housing and employment, are related to HIV acquisition and transmission.

- *Sanctuary Ordinance.* In 1989, San Francisco passed the "City & County of Refuge" Ordinance (a.k.a., the Sanctuary Ordinance) which prohibits City employees from helping Immigration & Customs Enforcement with immigration investigations or arrests unless such help is required by federal or state law or a warrant. The Ordinance is rooted in the Sanctuary Movement of the 1980s, when churches across the country provided refuge to Central Americans fleeing civil wars in response to the difficulties immigrants faced in obtaining refugee status. Municipalities across the country followed suit by adopting sanctuary ordinances. Recently, the Sanctuary Movement has experienced a rebirth in response to repressive immigration proposals in Congress and immigration raids that separate families. In February 2007, the Mayor of San Francisco reaffirmed the City's commitment to immigrant communities by issuing an Executive Order that called on City departments to develop protocols and training on the Sanctuary Ordinance.[50] The SFDPH adheres to the Ordinance and provides health promotion and health care services, including HIV prevention, care, and treatment services, to all individuals, regardless of immigration and citizenship status. In addition, all SFDPH employees and contract staff take an annual online "Sanctuary City" training. Completion of this training is documented in employee records.

Community Planning for HIV Prevention, Care, & Treatment

The HIV Prevention Planning Council[§]

With the release of the NHAS, in anticipation of new community planning guidance from CDC, and in response to various grant requirements for planning groups, San Francisco decided to reinvigorate community planning. Thus, the HPPC developed a new structure and processes to have the most impact with the greatest efficiency.

In 2011, the HPPC formed a work group to provide guidance regarding restructuring. The group had the following objectives:

1. To identify what key stakeholders should be involved in the planning process across the continuum of HIV prevention, care, and treatment to ensure broad-based community participation in a planning process (e.g., state, local, and tribal governments; businesses; faith communities; community/primary health care centers; other medical providers; housing, educational institutions; PLWHA; care planning groups; behavioral health; and other key stakeholders within the jurisdiction).
2. To identify the number of individuals that will provide parity, inclusion, and representation among planning members, while reducing level of effort.
3. To identify a new model that will ensure the completion of the primary task while reducing level of resources (e.g., number of meetings, committees).
4. To identify key tasks that must be accomplished in order to support the new planning framework (e.g., revise bylaws, policies and procedures, stakeholder recruitment and engagement process).

The work group presented its recommendations to the HPPC, which were approved in early 2012. The HPPC's new structure serves multiple needs as the:

- Community and Provider Planning Group for ECHPP;
- Behavioral Health/Primary Care Networking Council for the MAI-TCE grant; and
- HIV Prevention Group required by CDC for "Comprehensive HIV Prevention Program for Health Departments" funding.

The new structure of the HPPC includes 17 to 23 voting members, comprised of:

- 10 to 16 non-appointed voting members;
- A Governmental Co-chair appointed by the SFDPH;
- Two non-voting members (one each for Marin and San Mateo Counties to ensure the voice of the Metropolitan Division is supported in the planning process); and

[§] http://www.sfhiv.org/community-planning/hiv-prevention-planning-council/

- Six appointed voting members, representing the following key SFDPH divisions and government organizations:
  - HIV Health Services Planning Council
  - Mayor's Office of Housing (manages Housing Opportunities for People with AIDS)
  - SFDPH Community Behavioral Health Services
  - SFDPH Community-Oriented Primary Care
  - SFDPH Jail Health Services
  - SFDPH STD Prevention and Control

The HIV Health Services Planning Council**

The San Francisco HHSPC is a community planning group that oversees the prioritization and allocation of federal Ryan White Part A, Part B, and Minority AIDS Initiative funds allocated to the San Francisco EMA, which includes San Francisco, Marin and San Mateo counties. It is mandated by the U.S. Congress to determine the size and demographics of the population of individuals with HIV disease in this three county area. It is also called the "CARE Council" or "Ryan White Council."

The HHSPC has several major duties, including:

1. Determining the needs of PLWHA, especially those not in care;
2. Setting priorities for the allocation of funds;
3. Developing a comprehensive plan for the organization and delivery of health services; and
4. Assessing the efficiency of the grant administration and the effectiveness of services.

The HHSPC is also responsible for ensuring that services are coordinated with HIV prevention and substance use treatment. The HHSPC has a mandate to focus on people who are not in care (i.e., not receiving medical care) by assessing their needs and developing programs to bring them into care. The HHSPC takes on additional projects as needed or required.

There are forty seats on the HHSPC. The federal legislation prescribes a number of areas of representation such as PLWHA, CBOs, housing providers, and medical providers. The membership must reflect the demographics of HIV in the EMA. The members of the HHSPC represent the broad range of people concerned about HIV in San Francisco, San Mateo, and Marin counties.

The legislation mandates that at least 33% of HHSPC members be unaffiliated consumers of CARE services and that they reflect the demographics of HIV in the EMA. An "unaffiliated consumer" is a consumer of Ryan White Services that is neither employed by an organization receiving Ryan White funds nor is a member of a Board of Directors of an organization receiving Ryan White funds. In addition to the legislative requirement, the HHSPC mandates

** www.sfcarecouncil.org

itself to have a majority of members be PLWHA. In addition, at least one co-chair must be a PLWHA who is a consumer of services.

Integrated HIV Prevention and Health Services Planning

Since 2003, the HPPC and HHSPC have met jointly on an annual basis to discuss and determine priorities for areas that are relevant to the scope of both councils. In 2004, the PWP Committee of the HPPC was formed as a joint committee of the Councils. Beginning in 2006, the committee became a "standing committee" of both Councils and was renamed the Points of Integration between Prevention and Care (POI) Committee (due to the restructuring of the HPPC, the POI Committee concluded at the end of 2011). The Committee identified specific points of integration between prevention and care and built a foundation for effective, inclusive, and culturally appropriate PWP services. The guiding questions for the POI Committee were:

1. How can prevention and care work together to improve both HIV prevention and health services?
2. What are areas relevant to both Councils' goals and objectives?
3. How can the Councils work together (collaborate) more frequently?

Following local restoration of significant losses in federal Ryan White CARE Act and HIV prevention funding, San Francisco's HIV community expressed heightened interest in strengthening collaborative planning for HIV health services and prevention. Co-chairs and other representative members of both Councils met on July 10, 2012 and September 28, 2012 to consider a single integrated council for both care and prevention. The group settled on principles to guide the process, including the need for transparency in all deliberations on integration and to ensure community "buy-in" at every step. The group called for a thoughtful process without a rush toward an outcome. To that end, the group has proposed a timeline of at least a year to realize integration. In November 2012, both councils approved the creation of a formal workgroup to consider integration. The work group met for the first time in February 2013.

The SFDPH has conducted research to gather the experiences, both positive and negative, of jurisdictions with integrated health services and prevention planning councils. The workgroup will examine in detail the legislative and regulatory mandates of the two councils; the issues connected with synchronizing budget and planning cycles; and membership and bylaws issues. The SFDPH is exploring options to hire an appropriate consultant to facilitate the process.

HIV – Related Research in the SFDPH

San Francisco has a rich history of conducting cutting-edge HIV-related research and translating promising research findings into practice. The Bay Area is home to numerous research institutions including the University of California, San Francisco's (UCSF) AIDS Research Institute, which manages an impressive portfolio of HIV research[51]; San Francisco State University; and the University of California, Berkeley.

Unique among health departments in the United States, the SFDPH maintains a world-renowned research facility. This facility houses various studies within the HPS, Bridge HIV (formerly the HIV Research Unit), and the HIV Epidemiology Section. The research of these sections informs practice and is an integral part of our high-impact San Francisco HIV Prevention Strategy, which is grounded in the use of effective programs.

Research Conducted by the HPS

In addition to the previously mentioned PrEP demonstration project (a collaboration with STD Prevention & Control and Bridge HIV) and the STOP Study (a collaboration with STD Prevention & Control), research teams in the HPS work on a variety of projects with the goal of improving health in San Francisco (http://www.sfhiv.org/research/).

The Substance Use Research Unit investigates interventions designed to reduce the risk of HIV infection among populations bearing the greatest burden of disease. The Implementation Science & Evaluation Unit explores new ways to deliver and measure HIV public health programs. This work complements other HIV research programs within the SFDPH and benefits our community by generating new prevention strategies tailored to local epidemiology and local issues. At the same time, through sharing of results with outside agencies and scientists, this work can benefit other communities affected by HIV. A summary of current and planned studies is below.

TREX: TREX is a study testing the effectiveness of a monthly injection of naltrexone in individuals who use methamphetamine. Naltrexone is currently FDA approved for the treatment of alcohol dependence and for preventing relapse to opiate dependence. TREX is investigating whether it may help to reduce meth use, resulting in reductions in HIV-risk behavior.

Project ECHO: Project ECHO is a CDC-funded study to adapt and test the efficacy of Personalized Cognitive Counseling, a brief self-justification counseling intervention, on sexual risk and substance use among episodic substance-using HIV-negative MSM. Individuals are randomized to one of two study arms to receive (1) HIV rapid testing with adapted Personalized Cognitive Counseling or (2) HIV rapid testing with information only. Project

ECHO will evaluate whether the provision of Personalized Cognitive Counseling reduces risk behavior and STD acquisition in episodic substance-using HIV-negative MSM.

Project HOPE: Project HOPE is a multi-site, National Institutes of Health-funded study within the National Institute on Drug Abuse Clinical Trials Network; the SFDPH leads the clinical and intervention team for the trial, although the trial is not taking place in San Francisco because the PHAST and LINCS programs are our standard of care and the basis for the Project HOPE intervention. Project HOPE seeks to address issues around PLWHA who delay seeking care until their disease has progressed to the point where acute treatment is required. These patients may cycle in and out of public hospitals, and may not receive optimal HIV primary care; many use illicit drugs and may fail to follow up in HIV outpatient clinics. Project HOPE compares three strategies for linking and retaining hospitalized HIV-positive substance users to HIV primary care and substance use treatment. Participants will be randomized to one of the following interventions: Patient Navigator; Patient Navigator plus Contingency Management; or Treatment as Usual.

"Mirtazapine 2.0": The Substance Use Research Unit will initiate a study in 2013 to evaluate mirtazapine for methamphetamine dependence and sexual risk behaviors among MSM. The Unit previously documented the efficacy of mirtazapine for these outcomes[52], but the results were so promising that the randomized controlled trial will be replicated with a larger sample and modifications, including an adherence intervention and longer follow-up period.

Implementation Science & Evaluation Research: Various studies are underway to evaluate combination high-impact HIV prevention interventions through assessing clinical and public health outcomes along the continuum of HIV care. The research involves the development and utilization of novel assessment techniques, including CVL, time to virologic suppression, and the Institute of Medicine indicators for monitoring HIV care.[33]

Research Conducted by Bridge HIV

Bridge HIV (www.bridgehiv.org) is a clinical trials unit within the SFDPH and is affiliated with UCSF. Studies include research on HIV vaccines; other innovative biomedical prevention strategies, such as PrEP; and combination HIV prevention. Bridge HIV's research studies have been funded by NIH, CDC, and industry sponsors. Bridge HIV is an active member of several global HIV prevention networks, including the HIV Vaccine Trials Network, HIV Prevention Trials Network, and the Microbicides Trials Network. Bridge HIV has also pioneered the development of novel training methods to engage young and early career investigators in HIV prevention science. A summary of current and planned studies is below.

HIV Vaccines: Bridge HIV conducts a range of studies evaluating the safety and/or effectiveness of different vaccine strategies. In addition to testing the safety and tolerability of different vaccine products, these studies also evaluate the immune responses generated by these vaccines, and in some trials, whether the vaccine can protect HIV-negative persons from

infection. Bridge HIV has been involved in HIV vaccine research since the early 1990s with thousands of participants from the San Francisco Bay Area.

Pre-exposure prophylaxis (PrEP): In addition to the PrEP demonstration project described on page 59, Bridge HIV is conducting several PrEP studies to evaluate the safety and tolerability of new oral PrEP drugs (e.g., maraviroc, a newer HIV medication currently approved for treatment) as well as different PrEP formulations, including a rectal microbicide/gel that can be applied topically. Bridge HIV is also conducting the EPIC (Enhancing PrEP in Community Settings) study to develop and test innovative strategies to improve adherence to PrEP, including the use of mobile phone technologies and novel counseling strategies.

PUMA: The Prevention Umbrella for Transwomen and MSM in the Americas (PUMA) is a research project studying whether packaging HIV prevention strategies together might make them more effective at keeping MSM and transwomen free from HIV. The hope for PUMA is to encourage an active and healthy sex life while helping participants reduce their risk for HIV. The PUMA package may include Sex Pro (an online questionnaire that will help MSM and transwomen measure their risk for getting HIV); PrEP enhanced with strategies to improve medication adherence and reduce risk behaviors; couples counseling; and home HIV testing, along with the distribution of condoms, regular STD testing/treatment, and referrals/linkages to prevention services.

HOME: HOME is evaluating how home-based HIV self-testing can be used to reach young men of color. This study is described on page 44.

Research Conducted by the HIV Epidemiology Section

The SFDPH HIV Epidemiology Section consists of two units, the HIV Surveillance Unit and the HIV Bio-behavioral Surveillance Unit. The goal of the section is to provide HIV statistics and track emerging trends in HIV in San Francisco.

Government mandates apportion funding for prevention planning and medical and social services for HIV/AIDS patients to local jurisdictions on the basis of the number of reported HIV/AIDS cases for that area. The goals of the HIV Surveillance Unit are to monitor the incidence and prevalence of PLWHA in San Francisco and to follow the government mandates in an efficient, accurate, timely, and community-driven manner. The Surveillance Unit tracks the morbidity and mortality of persons with HIV/AIDS, and provides crucial data to monitor current and emerging trends in HIV transmission, characterize recent infections, and target prevention resources in San Francisco.

The Surveillance Unit provides an epidemiological window into HIV in San Francisco, allowing public health officials to more effectively and completely monitor HIV trends, allocate resources, and to plan and implement programs, particularly prevention programs. The surveillance program helps to identify areas of focus for PLWHA, and for community needs,

thereby helping guide prevention and care activities and resources to the people and populations at risk for HIV and/or in need of HIV/AIDS services.

The goals of the HIV Bio-behavioral Surveillance Unit are to assess the current level or burden of HIV infection among populations at risk, to monitor trends in transmission, to detect nascent sub-epidemics, and to find empirical evidence of the impact of community-wide prevention programs. HIV seroprevalence and seroincidence data contribute to our understanding of the epidemiology of HIV, the formation of sound health policy, the appropriate allocation of resources, and the planning of programs for the primary and secondary prevention of infection.

The HIV Epidemiology Section conducts the following research projects:

National HIV Behavioral Surveillance: The San Francisco arm of CDC's NHBS conducts ongoing research into HIV prevalence, incidence, and HIV risk behaviors among populations at high risk for HIV in San Francisco. NHBS is conducted in rotating annual cycles. In San Francisco, the four populations studied are MSM, IDU, transgender females, and heterosexuals at increased risk for HIV infection.

Medical Monitoring Project (MMP): San Francisco participates in CDC's MMP, a supplemental surveillance system designed to produce nationally representative data on clinical and behavioral outcomes among adults receiving medical care for HIV infection in the U.S. and Puerto Rico. MMP uses an appropriate sample of persons from which locally and nationally representative data can be derived. MMP involves interviewing patients and medical record abstraction to gather information about: demographics; access to care; HIV treatment and adherence; drug and alcohol use; sexual behavior; met and unmet needs for social services; and receipt of prevention counseling in a clinical setting.[††]

SHINE: SHINE is a cross-sectional cohort study of young transgender females in the San Francisco Bay Area examining risk trajectories and resilience related to HIV.

[††] More information on NHBS and MMP can be found at http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/surveillance.htm

Timeline for Implementation

The major implementation milestones for the San Francisco HIV Prevention Strategy have already been achieved (e.g., the HPS RFP, new community-based services established, LINCS program operational). We are looking forward to measuring outcomes and understanding the successes and challenges created by our approach. The San Francisco Comprehensive HIV Prevention Plan,[29] a complementary document to this one, outlines in detail the objectives of the Strategy and how we will measure outcomes.

Conclusion

The San Francisco HIV Prevention Strategy presents our upstream, structural approach to achieving the goals of the NHAS – to reduce new HIV infections; increase access to care and improve health outcomes for people living with HIV; and reduce HIV-related health disparities – and to achieve our local goal, to reduce new HIV infections by 50% by 2017.

The Strategy is for all of San Francisco. It is a synthesis of many existing documents, including the *2010 San Francisco HIV Prevention Plan*, the *2009 Centers of Excellence and CoE-Specific PWP Services RFP* (#20-2010), the *HIV Prevention Programs for Communities Highly Affected by HIV RFP* (#21-2010), *San Francisco's ECHPP Plan*, and the *San Francisco EMA Comprehensive HIV Health Services Plan 2012-2014*, among others. We offer the Strategy after many hours of careful, thoughtful, and respectful dialogue among the SFDPH and the HPPC, other community members, researchers, and community providers. It is the strongest approach to primary, secondary, and tertiary HIV prevention in these dynamic times. We hope that it provides what HIV prevention providers need in order to deliver the best services possible and to achieve the ultimate vision – to eliminate new HIV infections in San Francisco.

List of Acronyms

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
A-HIP	Augmenting High-Impact Prevention
AIDS	Acquire Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BAPAC	Bay Area Perinatal AIDS Center
CBHS	Community Behavioral Health Services, San Francisco Department of Public Health
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CL	Confidence Interval
CoE	Centers of Excellence
COPC	Community Oriented Primary Care, San Francisco Department of Public Health
CQI	Continuous Quality Improvement
CVL	Community Viral Load
DSRIP	Delivery System Reform Incentive Pool
ECHPP	Enhanced Comprehensive HIV Prevention Planning
EMA	Eligible Metropolitan Area
FY	Fiscal Year
HERR	Heath Education and Risk Reduction
HHS	HIV Health Services, San Francisco Department of Public Health
HHSPC	HIV Health Services Planning Council
HIV	Human Immunodeficiency Virus
HPPC	HIV Prevention Planning Council
HPS	HIV Prevention Section, San Francisco Department of Public Health
HOPWA	Housing Opportunities for People with AIDS
HRC	Human Rights Commission
HRSA	Health Resources and Services Administration
IDU	Injection Drug User
LIHP	Low-Income Health Program
LINCS	Linkage, Integration, Navigation and Comprehensive Services
MAI-TCE	Minority AIDS Initiative – Targeted Capacity Expansion
MSM/F	Males who have sex with males and females
MSM	Males who have sex with males
nPEP	non-Occupational Post Exposure Prophylaxis
NHAS	National HIV/AIDS Strategy
NHBS	National HIV Behavioral Surveillance
PCM	Prevention Case Management
PCSI	Program Collaboration and Service Integration

PEP	Post Exposure Prophylaxis
PHAST	Positive Health Access to Services and Treatment
PLWHA	People/Person Living with HIV/AIDS
PrEP	Pre-Exposure Prophylaxis
PUMA	Prevention Umbrella for Transwomen and MSM in the Americas
PWP	Prevention with Positives
RFP	Request for Proposal
RSVP	Re-engaging Surveillance-identified Viremic Patients
SAMHSA	Substance Abuse and Mental Health Administration
SFDPH	San Francisco Department of Public Health
SFGH	San Francisco General Hospital
SPNS	Special Projects of National Significance
STD	Sexually Transmitted Disease
STOP	Screening Targeted Populations to Interrupt Ongoing Chain of HIV Transmission with Enhanced Partner Notification
STOREE	San Francisco Tells Our Real Experience through Evaluation
TFSM	Transfemales who have sex with males
TMSM	Transmales who have sex with males
UCSF	University of California, San Francisco
WHO	World Health Organization
YMSM	Young Males who have sex with Males

Appendix I - For More Information

HIV/AIDS Epidemiology Annual Report, 2011, SFDPH
http://www.sfdph.org/dph/files/reports/RptsHIVAIDS/AnnualReport2011.pdf

2010 San Francisco HIV Prevention Plan, SFDPH
http://sfhiv.org/community.php

Various assessments sponsored by the SFDPH HIV Prevention Section, including the *African American and Latino MSM Action Plans*
http://www.sfhiv.org/resources/needs-assessments/

Appendix II – Guidelines for Routine HIV Screening & Testing According to Setting

City and County of San Francisco
Mayor Edwin Lee

Department of Public Health
HIV Prevention Section

Guidelines for Routine HIV Screening and Testing According to Setting

ROUTINE HIV SCREENING[‡‡] AND TESTING IN HEALTHCARE SETTINGS[§§]

- **General population**
  - Screen all persons aged 13 years or older for HIV at least once
  - Test all persons who request an HIV test
  - Repeat testing as clinically indicated[***]
- **High HIV prevalence populations**
  - Screen at least every 6 months in:
    - Gay or bisexual men and other males who have sex with males (MSM)
    - Injection drug users (IDU)
    - Transgendered persons (TG)
    - Persons with sex partners who are MSM, IDU, TG or HIV-positive
  - Consider screening every 3 months in MSM, IDU or TG if there is:
    - Methamphetamine, amyl nitrite/poppers, cocaine, or alcohol use (≥5 drinks/day)
    - Recent diagnosis of a sexually transmitted disease
- **Persons evaluated for sexually transmitted diseases (STD)[‡]**
  - Test MSM, IDU, and TG for HIV at time of evaluation
  - Test persons with sex partners who are MSM, IDU, TG for HIV at time of evaluation
  - Test for HIV in other persons seeking STD evaluation upon request
- **Pregnant women**
  - Screen all pregnant women for HIV as part of routine prenatal care

[‡‡] *Screening* refers to testing in the absence of signs, symptoms or known exposure.
[§§] Emergency and inpatient services, as well as all outpatient medical, public health, jail, and licensed substance use clinics.
[***] HIV antibody testing is not recommended more often than every 3 months unless there is suspicion for recent seroconversion.

Released March 29, 2012

Screening and Testing Processes in Healthcare Settings

- **Use an opt-out approach**
  - Inform patients that an HIV test will be performed unless it is declined
  - Provide an opportunity for patients to ask questions about the test
- **Verbal consent is sufficient**
  - Document verbal informed consent or refusal of HIV screening in the medical record
  - Written consent for HIV testing is not required in health-care settings, beyond the general consent for medical care
- **Counseling is not required, in most cases**
  - Risk-reduction counseling is not required for HIV testing in healthcare settings in California
  - California law requires that HIV counseling/information must be offered with prenatal care
- **Clinic flow**
  - Ancillary staff may carry out HIV screening with standing orders from clinical providers

HIV TESTING IN COMMUNITY-BASED PROGRAMS

- **High HIV prevalence populations**
  - Test at least every 6 months in:
    - Gay or bisexual men and other males who have sex with males (MSM)
    - Injection drug users (IDU)
    - Transgendered persons (TG)
    - Persons with sex partners who are MSM, IDU, TG or HIV-positive
  - Consider testing every 3 months in MSM, IDU or TG if there is:
    - Methamphetamine, amyl nitrite/poppers, cocaine, or alcohol use (≥5 drinks/day)
    - Recent diagnosis of a sexually transmitted disease
- **Other clients**
  - Test all persons requesting an HIV test on site, regardless of risk behavior or population
  - Refer all persons not from high HIV prevalence populations who request *repeat* HIV testing to a testing site that accepts all clients or to a medical clinic

Testing Processes in Community-Based Programs

- **Consent**
  - Written informed consent for HIV testing is required in all community-based sites
- **HIV counseling**
  - Risk-reduction counseling is not required for HIV testing
  - HIV counseling and education should be available upon request

ADDITIONAL GUIDELINES

Disclosure of HIV Test Results

- Patients and clients must contacted for result disclosure in the case of a positive test
- Disclose positive test results in person with trained personnel, if at all possible
- Do not use family members or friends as interpreters
- Post-test counseling must be provided to all persons testing positive
- All persons testing positive must be linked to an HIV care provider
- HIV testing must be offered for sex and injection partners of all persons testing positive

SFDPH Services

- LINCS (Linkage Integration Navigation Comprehensive Services) Program
  - HIV partner notification
  - Linkage to HIV care and ancillary services
  - Navigation to HIV care, including outreach and escort to care appointments
  - HIV test result disclosure
- Other SFDPH services
  - HIV testing and treatment guideline support
  - Testing resources
  - Technical assistance and written literature about HIV testing
  - Training for HIV testing and counseling
  - Confidential case reporting

Appendix III - San Francisco Department of Public Health, HIV Prevention Section Request of Proposals RFP No. 21-2010 ***"HIV Prevention Programs for Communities Highly Affected by HIV"***

HIV Prevention Section Request for Proposals may be found online at:

http://www.sfhiv.org/resources/2010-request-for-proposals/

Appendix IV - Policies and Operations Manual for HIV Testing Services in Community Based Settings

The *Policies and Operations Manual for HIV Testing Services in Community-Based Settings* may be found online at:

http://www.sfhiv.org/wp-content/uploads/San-Francisco-Policies-and-Operations-Manual_20121.pdf

Appendix V - CDC PS12-1201 Required & Recommended Components

REQUIRED	PART OF SAN FRANCISCO HIV PREVENTION STRATEGY	FUNDING SOURCE(S) BUDGET YEAR 2012
HIV testing	✓	CDC, PS 12-1201 (BASE); CDC, Expanded Testing Initiative (ETI); Local General Fund (GF)
Comprehensive prevention with HIV-positive individuals	✓	BASE; HRSA; CDC, ECHPP (ECHPP); GF
Condom distribution	✓	BASE; ECHPP
Policy initiatives	✓	BASE; ECHPP; ETI; GF

RECOMMENDED	PART OF SAN FRANCISCO HIV PREVENTION STRATEGY	FUNDING SOURCE(S) BUDGET YEAR 2012
Evidence-based interventions for HIV-negative people at highest risk of acquiring HIV	✓	BASE; GF
Social marketing, media, and mobilization	✓	BASE; GF; ETI; ECHPP
PrEP and nPEP	✓	ECHPP; GF; NIDA (PrEP)

ADDITIONAL	PART OF SAN FRANCISCO HIV PREVENTION STRATEGY	FUNDING SOURCE(S) BUDGET YEAR 2012
Syringe access and disposal	✓	GF

Appendix VI. Summary of Programs Funded by the SFDPH HIV Prevention Section

NAME & ADDRESS OF AGENCY	SERVICES PROVIDED	SUBCONTRACTOR(S)	FUNDING SOURCE(S)
AGUILAS 1800 Market Street 3rd Floor Suite Q32 San Francisco, CA http://sfaguilas.org	HIV testing; individual counseling sessions; discussion groups; skill-building groups; and prevention services for Latino MSM over the age of18 who are Spanish and/or English-speaking, of varied socioeconomic backgrounds, and are immigrant, first generation, an multi-generations at high-risk for HIV.	San Francisco AIDS Foundation www.sfaf.org	**HPS RFP Category 5
Asian and Pacific Islander Wellness Center 730 Polk Street San Francisco, CA 94109 http://www.apiwellness.org	Single- and multiple-session groups; recruitment and linkage; events; prevention case management in an effort to increase status awareness, increase levels of protected sex, increase viral load suppression, reduce substance use harm or obtain treatment for substance use addressing drivers, and increase access to safer injection supplies among transgender females of color.	El/La http://ellaparatranslatinas.yolasite.com Instituto Familiar de la Raza www.ifrsf.org Native American AIDS Project www.naap-ca.org	**HPS RFP Category 7
	A wrap-around drop-in service center offering psycho-educational workshops; case-management; linkage and referrals; and social support services for transgender clients to improve their health and well-being and reduce risk for HIV and substance abuse.		General Funds
	Outreach and recruitment; single- and multiple-session groups; individual health education & risk reduction sessions; and linkages to services for Asian and Pacific Islander MSM.		General Funds
Instituto Familiar de la Raza 2919 Mission Street San Francisco, CA 94110 http://ifrsf.org	Multiple- and single-session groups; prevention case management; community events; HIV testing; linkage to care to U.S. born and immigrant Latino MSM, with an emphasis on those who live or socialize in the Mission,	Mission Neighborhood Health Center www.mnhcf.org	**HPS RFP Categories 2 and 5

Appendix VI. Summary of Programs Funded by the SFDPH HIV Prevention Section

NAME & ADDRESS OF AGENCY	SERVICES PROVIDED	SUBCONTRACTOR(S)	FUNDING SOURCE(S)
	Tenderloin, South of Market and Castro areas.	San Francisco AIDS Foundation www.sfaf.org	
Mission Neighborhood Health Center 240 Shotwell Street San Francisco, CA 94110 www.mnhc.org	Primary care; psychiatric consultation; case management; treatment adherence risk reduction counseling; mental health and substance use counseling to HIV-positive Latinos/as, with a focus on uninsured monolingual Spanish-speaking or with limited English proficiency, who live at or below the poverty level.	Instituto Familiar de la Raza www.ifrsf.org	*HHS/HPS RFP
San Francisco AIDS Foundation 1035 Market Street # 400 San Francisco, CA 94103 http://www.sfaf.org	Status Awareness: HIV testing for MSM, IDU, TFSM at various locations and linkage into HIV primary care services and partner services for clients diagnosed with HIV. Prevention With Positives: Individual and group counseling, overall health and well-being seminars for MSM who are newly diagnosed with HIV/AIDS or struggling with managing their HIV medical care. Mobile HIV testing and HIV prevention services and support specifically for African American MSM. Syringe Access: Coordinates the citywide distribution of safer sex and injection materials. Provides referrals, medical care, HIV and hepatitis C testing. Maintains inventory of ordering, bio-waste disposal and data collection from members of the Syringe Access Collaborative. Gay Men & MSM Services: HIV testing; individual/group counseling; low-threshold services to address drivers and	Glide www.glide.org St. James Infirmary www.stjamesinfirmary.org Asian & Pacific Islander Wellness Center www.apiwellness.org Homeless Youth Alliance www. homelessyouthalliance.org	**HPS RFP Categories 1,2, 3, 4, 6, and 8 *HHS/HPS RFP

Appendix VI. Summary of Programs Funded by the SFDPH HIV Prevention Section

NAME & ADDRESS OF AGENCY	SERVICES PROVIDED	SUBCONTRACTOR(S)	FUNDING SOURCE(S)
	HIV-related health disparities among gay men and other MSM. Specific services to address HIV-related health disparities among African American MSM, with a focus on gay males Prevention with Positives Center of Excellence: Prevention case management and treatment adherence groups with the goal of suppressing viral load, reducing HIV risk behavior, reducing co-morbidities, and reducing/eliminating barriers to adherence and engagement among MSM, TFSM, and IDU.		
STD Prevention and Control, SFDPH 356 7th Street San Francisco, CA 94103 http://sfcityclinic.org	HIV testing; HIV risk-reduction counseling; STD testing and treatment; partner services; nPEP; referral and linkage to primary medical care to MSM, transgender females, IDUs, and their sex and needle-sharing partners and social network contacts, who test positive for HIV.		**HPS RFP Category 1
Southeast Health Center 2401 Keith Street San Francisco, CA 94124 www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/SEHlthCtr.asp	Comprehensive physical exam and evaluation; case management; mental health and substance abuse counseling services; outreach; health education; and treatment adherence to low income, uninsured or underinsured, HIV-positive African Americans.		*HHS/HPS RFP
Tom Waddell Health Center 50 Lech Walesa (Ivy) Street San Francisco, CA. www.sfdph.org/dph/comupg/oservic	Site-base general primary medical care; comprehensive health assessments; treatment; and referrals to specialty ancillary, and tertiary services as need. Target populations are low-income individuals who are a) multiply diagnosed		*HHS/HPS RFP

Appendix VI. Summary of Programs Funded by the SFDPH HIV Prevention Section

NAME & ADDRESS OF AGENCY	SERVICES PROVIDED	SUBCONTRACTOR(S)	FUNDING SOURCE(S)
es/medsvs/hlthctrs/tomwaddellhlthctr.asp	(HIV infection with concurrent mental health disorder and/or chemical dependency), and b) HIV-positive individuals who are currently outside the system of care or receiving suboptimal care, homeless or marginally housed and live in the Tenderloin or Sixth Street Corridor.		
UCSF Alliance Health Project 1930 Market Street San Francisco, CA 94102 http://www.ucsf-ahp.org	HIV testing; prevention counseling; limited STD testing; referrals to related services; linkage to medical care and partner notification to residents of San Francisco, targeting populations most impacted by HIV (MSM, IDU, TFSM).	San Francisco AIDS Foundation www.sfaf.org	**HPS RFP Category 1

*RFP No. 20-2010 Centers of Excellence and CoE-Specific Prevention with Positives (PwP) Services

**HIV Prevention Section (HPS) RFP #21-2010 HIV Prevention Programs for Communities Highly Affected by HIV
Category 1: Community-based HIV Testing
Category 2: Health Education/Risk Reduction (HERR) to Address Drivers among MSM, with a Focus on Gay Males
Category 3: Prevention with Positives (PWP)
Category 4: Special Projects to Address HIV-Related Health Disparities Among African American MSM, with a Focus on Gay Males
Category 5: Special project to address HIV-Related disparities among Latino Males who have sex with males (MSM), with focus on gay males
Category 6: Special Projects to Address HIV-Related Health Disparities Among MSM, with a Focus on Gay Males
Category 7: Special Projects to Address HIV-Related Health Disparities Among TFSM
Category 8: Citywide Syringe Program: Access, Disposal, Program Coordination, and Bulk Purchasing

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PART 2

Jurisdictional HIV Prevention Plan for Marin County, 2012-2016

Introduction & Background

Marin County is a small, suburban county directly north of San Francisco. Bordered on three sides by the ocean and the San Francisco Bay, with a population of 254,209 and 519 square miles of land, Marin has low population density and much geographic diversity with over 40 cities, towns, and unincorporated districts. Marin has one of the highest per capita incomes in the United States, but there are still residents living in poverty and/or who do not make enough income to be self-sufficient.

In 2009, the State of California eliminated funding for Marin's HIV prevention and testing services. With a large unfunded pension obligation, the County was not able to backfill any of this loss, but continued to provide HIV testing at the County STD Clinic. Marin AIDS Project (MAP), a local AIDS service organization, also offered site-based HIV testing supported by private funding. In 2011, Marin County Department of Health and Human Services (MCDHHS) was able to partner with San Francisco and San Mateo counties to apply and receive CDC HIV prevention funding. MCDHHS has partnered with MAP to launch an outreach and testing program that provides individualized rapid response targeting those at highest risk of HIV infection.

Planning/Engagement in Marin

The MCDHHS HIV/AIDS Program has strong collaborative ties to community stakeholders. Marin had a Local Implementation Group for HIV prevention from 1995 to 2009 that disbanded with the elimination of state funding. Marin also has an active Marin HIV/AIDS Care Council which prioritizes and allocates local Ryan White funding for treatment and care services. To begin the stakeholder engagement process, in 2011, MCDHHS held a focus group to plan for testing and needle exchange services. Began in November 2012, MCDHHS convened stakeholders to provide feedback on the HIV Prevention Plan. The invited stakeholders included: representatives of Marin's HIV/AIDS service organizations; drug treatment providers; all clinics, including STD, HIV/AIDS specialty, communicable disease providers, jail services, services for high risk youth, HIV medical care and support services, Planned Parenthood, Federally Qualified Health Centers; and the Marin HIV/AIDS Care Council. Stakeholders will be convened on an annual basis to review the Plan and their feedback will be used to modify the Plan, as needed.

Overall Goals

Marin County's primary goals are to **find and test** the 20% of infected individuals who do not know their HIV status, **link** HIV positive individuals to care and **treat** them with medications. Marin's secondary goal is to reduce disparities in new HIV infections.

In 2012-2016, Marin County hopes to do this through a focus on three core prevention activities:

- Providing targeted HIV testing
- Encouraging routine HIV testing

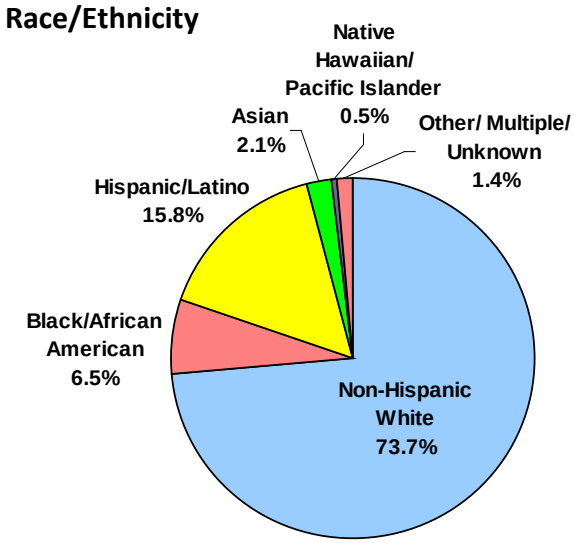
- Engagement and retention in HIV medical care

Marin's goals are in alignment with the San Francisco HIV Prevention Strategy and the NHAS.

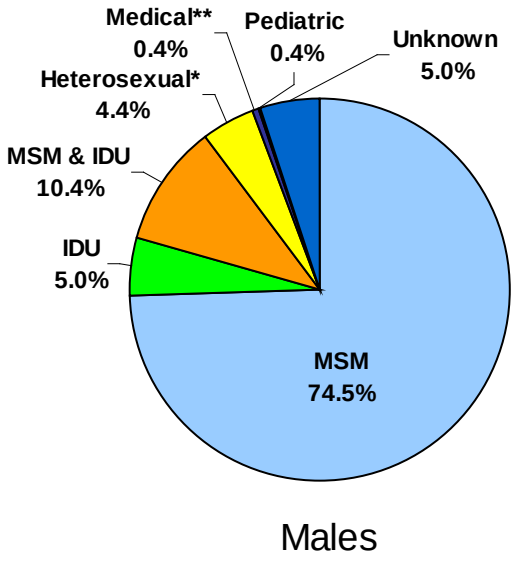
Marin's Epidemiological Profile

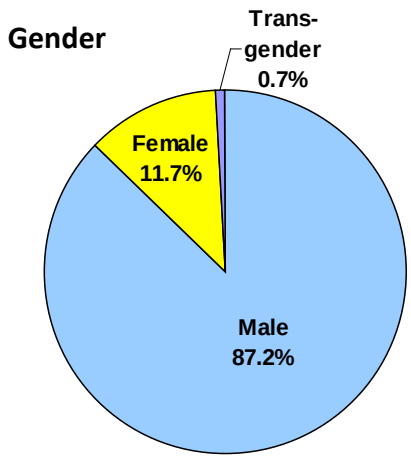
As of December 31, 2011 there are 570 PLWHA Marin County (excluding PLWHA in San Quentin State Prison, which is located in Marin County)[10]. There have been a cumulative total of 1,329 reported cases since 1982.

Of the living cases, the majority are male, white, and over 40 years of age. One in five cases is over 60 years old. The primary transmission category for males is sex with another male



Transmission Category





[10] According to EHARS, the State of California HIV Surveillance System

Trends among new HIV diagnoses in Marin County

Marin County averaged 20 new HIV diagnoses per year during 2006-2011.

- Diagnoses for Latinos (32.4%) and African Americans (AA) (8.1%) in the last two years are disproportionate to their percentages of the Marin County population. [11]
- The percentage of new diagnoses attributed to male-to-male sexual contact has been steadily increasing since 2008.

Approximately half of people with new HIV diagnoses continue to be diagnosed with AIDS within one year after diagnosis.

High-risk populations in Marin

The behavioral risk populations identified with the greatest burden of the epidemic and those determined to be at greatest risk for HIV transmission and acquisition in Marin are:

- MSM
- IDU
- MSM-IDU
- Sexually active Latinos and African Americans who have not had an HIV Test

Current Prevention and Treatment Resources Table

Service Description	Target Populations	Service Provider(s)	Geographic Location	Funding Source(s)
Targeted outreach and rapid HIV Testing	MSM MSM-IDU IDU AA/Latinos (not tested)	MCDHHS and MAP, Marin Treatment Center Jail Medical Services	Central San Rafael, Canal, Marin City, Novato County Wide Correctional Facilities	CDC prevention funding SAMHSA funding County
Routine HIV Testing	All	STD Clinics, FQHCs, Community Clinics, Reproductive Health Clinics	County Wide	Family PACT, Public and Private Insurance
HIV Treatment and Retention in Care HIV Support Services PCRS Services[12]	HIV+ and Partners	Kaiser Permanente, Tom Steel Clinic, MAP, MCDHHS Clinics	Central San Rafael Mill Valley Provides services County Wide	Ryan White, ADAP, Public and Private Insurance, Private donations
Transitional Housing	HIV+	MAP, Hamilton	Novato	HOPWA
Prevention Education	All (Primary Prevention)	Huckleberry Youth Programs, MAP	High Schools , Teen Clinics in San Rafael and Novato	California Endowment (funding ended in

[11] According to 2010 Census data, Latinos comprise 15.5% and African Americans comprise 2.6% of the Marin County population.

[12] Partner Counseling and Referral Services

				2012)
Outpatient and Residential Drug Treatment	HIV+	Marin Treatment Center, Centerpoint, Helen Vine	Central San Rafael	Ryan White SAMHSA funding, Public and Private Insurance
Needle Exchange	MSM-IDU IDU (Primary Prevention)	MAP		Private donations

Core Prevention Strategies

Providing Targeted HIV Testing

MCDHHS, in collaboration with MAP, is providing targeted outreach and rapid HIV testing. The program conducts street outreach in Marin City; downtown San Rafael and the Canal; local food banks (Canal and Novato); service agencies for new Latino immigrant arrivals (Canal Alliance); community centers reaching African American youth (Phoenix Academy); and soup kitchens/dining halls for the homeless or marginally housed individuals (St. Vincent's). Testing is offered on a drop-in basis at some fixed sites. [13] The program uses a testing "on demand" model with a staffed hotline that enables callers to ask for HIV testing and receive an HIV test the same day or the next day at a nearby location (if they meet high-risk criteria). The target MSM population in Marin is difficult to reach, because there is no central area/district where MSM socialize, so the program will develop and tailor outreach approaches through word-of-mouth and internet/social media to promote the service. The program hopes to expand, using the CDC Social Network model, in future years.

Activities	**Agency Responsible**	**Timeline**
Street Outreach Condom Distribution HIV Testing Social Network Testing	MCDHHS MAP	**2012-2016**

Encouraging Routine HIV Testing

With half of HIV diagnoses progressing to AIDS within a year after diagnosis, it is likely that individuals are missing previous opportunities to test when they are engaged with medical providers. The program plans to encourage the systematic testing and screening for HIV by offering information about the local epidemic and technical assistance to local clinics who are interested in implementing HIV testing. Clinics may not be aware of the ability to do opt-out testing. Many of the new infections in the last several years have been identified in health care settings.

[13] MAP, St. Vincent's, the Phoenix Academy, Rotacare, Center Point and Novato Wellness Center.

Activities	Agency Responsible	Timeline
Provider In-services Technical Assistance Pilot Programs	MCDHHS Individual Clinics	**2012-2016**

Engagement in Care and Treatment Services

HIV medical care is provided by MCDHHS Clinics, Tom Steel Clinic, and Kaiser Permanente. A variety of other supportive services that keep people in care are provided by MAP. Most of these service providers are located near central San Rafael, and one is in Mill Valley. Additionally, the MCDHHS HIV/AIDS Program provides targeted outreach to African Americans and Latinos who have not been in care or are lost to follow up.

Activities	Agency Responsible	Timeline
HIV Medical Services Supportive Services Linkage to Supportive Services Minority AIDS Initiative Outreach PCRS	Tom Steel MCDHHS Clinics & HIV/AIDS Program Kaiser Permanente MAP	**2012-2016**

Additional Prevention Strategies for 2012-2016

The following table represents other potential activities in various stages of implementation that could be of additional focus for Marin's prevention activities in the next several years. Marin will be challenged to provide these program activities without additional resources because there are few funding streams specifically for HIV prevention, care and treatment other than state and federal funding. However, any new funding will be prioritized according to these service needs.

MCDHHS has several new initiatives, such as the integrating of physical health, mental health, and substance use services, and the establishment of a prevention and communications team, which can be used as a conduit for developing countywide policies, providing trainings, coordinating resource sharing, and coordinating key messages about HIV outreach and testing for individuals and the media.

Activities	Implementation Status	Action Steps	Agency(s) and Groups Responsible	Timeline
Syringe Access & Disposal Programs	Implemented	Review status, look for local sustainable funding	MAP MCDHHS	**2012-2016**
nPEP PrEP	Not implemented	Establish policy and agreements with Emergency Rooms	Hospitals MCDHHS	**2013-2016**

Stigma Reduction, Social Marketing and Media	In Process	Develop and implement Marin-specific communications plan	MCDHHS Communications Team MAP Marin HIV/AIDS Care Council	**2013-2016**
Policy Initiatives: Service Integration and Infrastructure Developments	In Process	Harm reduction training, jail testing, referral networks, coordination with hepatitis C and other communicable disease efforts	MCDHHS, Public Health, Mental Health and Substance Use MCDHHS Prevention Hub	**2013 2016**
Evidence-based Interventions for HIV-negatives	Not Implemented	Explore feasibility of volunteer based program Look for funding	MAP MCDHHS	**2013-2016**

Conclusion

This Plan is limited by the resources we have, and many of the interventions follow categorical funding. However, we will continue to leverage and provide in-kind resources whenever possible to promote primary prevention efforts aimed at keeping people HIV negative. This plan has been developed by the MCDHHS HIV Program; it is our hope that the implementation of this Plan will be the shared responsibility of the HIV Program and our collaborative partners. We will be reviewing this plan and our progress annually and making adjustments as necessary. Any questions about this plan can be directed to Cicily Emerson at cemerson@marincounty.org, 415-473-3373.

PART 3

Jurisdictional HIV Prevention Plan for San Mateo County

San Mateo County Health System
Jurisdictional HIV Prevention Plan
2012 – 2016

Overview of San Mateo County

San Mateo County is located in the San Francisco Bay area of California. It covers most of the San Francisco Peninsula just south of San Francisco, and north of Santa Clara County. The county is comprised of mostly suburban and rural areas with a few small urban centers. According to the 2010 US Census, the population of San Mateo County was 718,451 with predominant racial compositions of 53.4% white, 26.2% Asian/Pacific Islander, 25.4% Hispanic (of any race), and 2.6% African American.

HIV/AIDS Epidemiology

HIV/AIDS Prevalence: As of December 2011, there were 1,467 PLWHA in San Mateo County. Of that total of people living with HIV disease, 924 of them were living with AIDS. Males continue to make up the vast majority of people living with HIV disease (83%)--mostly MSM (58%). More than half of PLWHA are over the age of 50 years (51%). One of the most striking features of the HIV/AIDS epidemic in San Mateo County is that people who identify no risk or whose risk is unknown account for the second highest proportion of living HIV cases (13%). African Americans continue to be disproportionately burdened with HIV disease in San Mateo (14%) although they make up less than 3% of the county's population.

HIV Incidence: As of December 2011, there were 107 newly diagnosed cases of HIV in San Mateo County. Again, males make up the majority of cases (88%) with MSM accounting for over half of all new cases (52%). Notably, people who identify no risk or whose risk is unknown account for almost one-third of all new HIV cases (32%). Racial/ethnic minorities make up almost three-quarters of newly diagnosed HIV cases (72%).

Below is a figure that displays characteristics of newly diagnosed HIV/AIDS cases from 2007-2011.

Characteristics of Newly Diagnosed HIV/AIDS Cases, By Year of Diagnosis, San Mateo County, 2007 – 2011*

	2007	2008	2009	2010	2011
Total Number	79	91	70	93	107
Gender					
Male	90%	86%	81%	78%	88%
Female	10%	13%	17%	17%	12%
Transgender	0%	1%	1%	4%	0%
Race/Ethnicity					
White	41%	34%	36%	28%	25%
Black	8%	19%	9%	11%	12%
Latino/Hispanic	39%	37%	47%	33%	32%
Asian Pacific Islander	5%	7%	7%	19%	28%
Multi-Race/Other/ Unknown	8%	3%	1%	9%	3%
Exposure Category					
MSM	58%	51%	49%	53%	52%
IDU	6%	3%	1%	5%	2%
Heterosexual Contact	13%	12%	13%	9%	7%
MSM/IDU	3%	5%	4%	1%	7%
Other Risk/ Not Specified	20%	29%	33%	32%	32%

*San Mateo County data are reported through December 31, 2011, from the electronic HIV/AIDS Reporting System (eHARS)

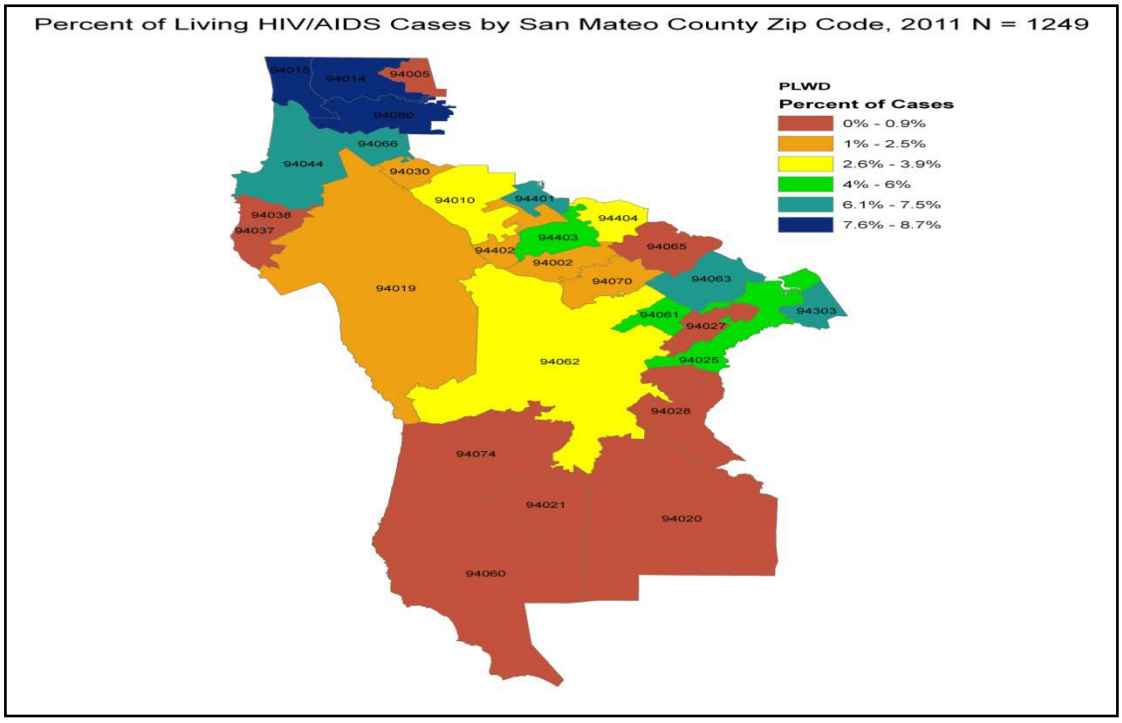
Emerging Trends in HIV Transmission and Acquisition

HIV Incidence: Rates in San Mateo remain highest among African Americans (24 per 100,000), Hispanics (13 per 100,000), and whites (8 per 100,000); however, HIV incidence rates are increasing among Asian/Pacific Islanders (5 per 100,000), as shown by a tripling in the proportion of new HIV infections over the last three years.

Behavioral Risk Exposure: MSM remain the most reported risk behavior among people testing HIV positive. People who identify no risk or whose risk is unknown persist as the second most reported risk behavior. Upon closer review of HIV testing data, there appears to be a correlation between new HIV infections and heterosexual sex while high on non-injected drugs (*California Office of AIDS Local Evaluation Online (LEO) database; FY2011-12*).

Racial/Ethnic Disparities: Based upon demographics of reported STDs, HIV infections, and new AIDS diagnoses over the past 5 years, two racial/ethnic populations show increased vulnerability to HIV transmission and acquisition. African Americans make up less than 3% of the population and bear a disproportionate burden of HIV disease anywhere in the county. Likewise, Hispanics in two zip codes, 94063 (Redwood City/North Fair Oaks) and 94080 (South San Francisco and north county), emerge as another population at increased risk for HIV transmission and acquisition. There has also been a notable increase in the proportion of recent cases attributed to the Asian/Pacific Islander community. A closer look at recent data reveals that more than half of all recent new HIV infections among Asian/Pacific Islanders are among MSM.

Below is a figure that displays the geographical distribution of PLWHA in San Mateo in 2011. The highest concentrations of HIV are in the northern tip of the county that borders San Francisco. High concentrations are also identified in the mid-to-lower eastern part of the county where both African Americans and Hispanics represent a greater proportion of the population.



Based upon a review of the epidemiological data, the following priority populations have been identified for the period 2012-2016:

1. MSM
2. Heterosexual sex while high on non-injected drugs
3. Racial/ethnic special population: African Americans countywide
4. Racial/ethnic special population: Hispanics in zip codes 94063 and 94080

Resources for HIV Prevention, Care and Treatment

Like most jurisdictions, San Mateo County has experienced significant decreases in funding for HIV prevention, care and treatment activities since the Great Recession. In 2008, over two-thirds of all funding for HIV prevention activities was cut as a result of reductions to the CDPH Office of AIDS. The majority of HIV prevention, care, and treatment services in San Mateo County are coordinated and delivered through a centralized service delivery system within the San Mateo County Health System (SMCHS). The HIV prevention and STD units have been integrated since 2008, and the staff members have been cross-trained to provide HIV testing, counseling, and partner services. In program year 2012, San Mateo County became part of the San Francisco MSA and now receives its CDC funds for HIV prevention through the SFDPH. HIV prevention services are solely delivered by county employees, and there are no CBOs providing services through subcontract agreements. HIV care and treatment services, pharmacy assistance, medical case management, mental health, and substance use support for PLWHA are all provided through SMCHS. Ancillary and support services for HIV care are provided through two subcontract agreements with CBOs.

FUNDING SOURCE	ACTIVITIES FUNDED
San Mateo County General Funds	Syringe exchange STD testing and treatment
CDC HIV Prevention Funds (through SFDPH)	HIV testing and outreach Risk-reduction counseling Drop-in support group Partner services Linkage to care PWP Condom Distribution Media/Community mobilization
SAMHSA – HIV Set-Aside (Interagency Memorandum)	HIV testing and education in alcohol and drug recovery programs
Ryan White Part A/B	Comprehensive HIV primary care Pharmacy assistance Ancillary support services
HOPWA	Rent/mortgage assistance Utility assistance Case management
Ryan White – Minority AIDS Initiative	Linkage to/retention in care for minority HIV-positive clients

Needs Identified to Improve HIV Prevention, Care and Treatment

In the face of limited resources for HIV prevention planning in recent years, San Mateo County has not undertaken a coordinated needs assessment process since its last strategic plan in 2008. However, discussions are ongoing about HIV prevention and care program needs. SMCHS participates in the following departmental/program unit meetings and external stakeholder-led planning activities:

- Monthly HIV Community Board meeting
- Bi-monthly HIV prevention unit team meeting
- Semi-annual HIV prevention unit planning meeting
- Monthly Joint STD/HIV Prevention meeting
- Monthly STD Prevention unit meeting
- Monthly STD/HIV Clinic Operations Leadership Meeting
- Monthly Alcohol and Other Drugs Treatment Provider's Meeting
- Monthly African American Community Health Advisory Committee
- Quarterly Public Health Leadership Meeting

Ongoing participation and inclusion in these meetings allows SMCHS to integrate HIV prevention and care needs into multi-disciplinary service environments. As part of the preparation of this Jurisdictional HIV Prevention Plan, the HIV prevention supervisor provided an overview of HIV/AIDS epidemiology in San Mateo County, along with a table of the Continuum of HIV Prevention Activities and Strategies, to each of the above listed bodies. Through participation in these meetings, the following needs have been identified and prioritized:

Expand community-based capacity to provide HIV prevention services: The vast majority of HIV prevention and care services are provided through SMCHS employees. In order to more effectively reach and serve the most at-risk populations, there is a great need to decentralize services and locate them closer to the communities at-risk. This will entail partnering with providers already in those communities that are not traditional HIV prevention providers.

Improve outreach and testing targeting MSM: The MSM population in San Mateo County is a hard-to-reach population. This can be attributed to the fact that there are no traditional venues where MSM congregate: i.e. gay bars, clubs, bathhouses, gay community centers, etc. MSM who access HIV prevention services in San Mateo County have identified the internet as a primary method for connecting with other MSM. Additionally, providers in healthcare settings have identified a need for capacity-building to conduct better behavioral risk assessments.

Improve coordination with substance use treatment and recovery programs: To a degree, HIV prevention and care services have already been integrated with substance use recovery services. However, substance use providers have identified a need to integrate more harm reduction skills development, along with substance use policy clarification, related to the intersection between substance use and HIV prevention.

Expand HIV testing in healthcare settings: The majority of new HIV cases in San Mateo County are identified through HIV testing that originated in a healthcare setting. Yet, many providers have expressed that they do not routinely screen patients for HIV, but rather, patients are screened for HIV based upon triage or symptoms. Providers need a greater awareness of the *CDC Recommendations for HIV Testing in Healthcare Settings-2006*, as well as capacity-building assistance with disclosure of HIV test results, linkage to HIV primary care, and partner services.

Develop a coordinated data-gathering system: One of the greatest challenges to monitoring and evaluating the impact of HIV prevention and care activities is the lack of a coordinated data-gathering system. Previously, HIV prevention activities were tracked through the CDPH Office of AIDS database, LEO. Currently, all HIV testing activities are tracked in Evaluation Web; and, non-HIV testing activities are tracked in a simple Excel spreadsheet. HIV care and treatment services are tracked in ARIES along with the electronic medical record implemented throughout the SMCHS. SMCHS has an ongoing need for a coordinated data-gathering system that communicates, exchanges, and interfaces with multiple systems of data-gathering to better analyze and evaluate program outcomes and assist in planning efforts.

Gaps to be Addressed and Rationale for Selection

Although MSM make up the majority of HIV cases in San Mateo County, individuals who identify MSM-related risk behaviors make up a much smaller proportion of HIV prevention contacts and services. As noted before, MSM are primarily a "hidden" population in the county. Because this population bears the greatest burden of HIV disease, HIV prevention activities and strategies will be scaled up to target early intervention services as a major priority in this plan.

The lack of a coordinated data system limits the ability to set goals and monitor program activities; identify emerging service needs and trends; and effectively measure success of HIV prevention efforts. SMCHS needs to develop coordinated systems for data-gathering, monitoring, and evaluation for HIV prevention and care. Along with the need to develop a coordinated data system, SMCHS has identified a need for consistent and ongoing activities for community engagement to assess unmet prevention and care needs, and to identify and highlight improvements in the service delivery system.

Continuum of HIV Prevention Activities and Strategies to Address HIV/AIDS Epidemic

ACTIVITY	STRATEGY	
HIV Testing and Outreach	Mobile prevention Testing on demand Risk-reduction counseling Routine HIV testing in healthcare settings Partner services referrals	Social Network Testing HIV/HCV Counseling AOD Recovery sites Geo-locating/Internet Correction/Jails/Juvenile
Partner Services	Newly diagnosed HIV+ New to HIV care Annual offers to existing HIV +clients	New STDs in HIV+ HIV provider referrals Integration with HIV care
Linkage to Care	Integration with HIV care Electronic medical record communication Expedited labs, scheduling, transport, triage	MAI and Prevention Intensive follow-up Mobile vans
Prevention with Positives	Individual risk-reduction counseling Primary care provider referrals	Integration with HIV care Drop-in Support Group
Syringe Exchange	Mobile prevention/on-demand exchange HIV primary care Other healthcare settings	AOD Recovery sites STD Clinic
Condom Distribution	Target population outreach (schools, colleges, AOD recovery sites Homeless shelters	Barbershops, salons, etc. STD Clinic Community events
Media/Community Mobilization	HIV Awareness Day events Health fairs/community events	Geo-locating/Internet Web-based information

HIV Prevention Strategy

Outreach and testing targeting MSM: Given that MSM comprise the majority of HIV cases in San Mateo, the strategy to target this hidden population will require the use of internet-based and geo-locating technology to effectively provide HIV prevention activities. The "virtual venues" that exist through technology are highly utilized by MSM in San Mateo County to connect for sexual encounters. SMCHS has begun establishing a presence in popular internet-based chat rooms, websites, and on geo-locating applications to passively engage MSM, deliver HIV prevention messages, and provide referrals to HIV testing and linkage to HIV prevention and care services. Additionally, SMCHS staff has been trained to and will implement Social Network HIV testing to engage MSM in referring members of their sexual networks for HIV and STD testing.

Comprehensive PWP: The SMCHS STD/HIV Program includes staff across the continuum of HIV prevention and care services. This allows for a closely coordinated response when an individual is newly diagnosed as HIV-positive or an existing HIV-positive client is in need of HIV prevention services. HIV prevention staff that conduct field-based outreach and testing also provide linkage to and retention in care for those who are newly diagnosed or have fallen out of care; partner services; and risk-reduction counseling. The STD unit refers both new cases and existing HIV cases with new STD infections to HIV prevention staff for more intensive follow-up for partner services, linkage to care, and intensive risk-reduction counseling.

Routine HIV testing in healthcare settings: SMCHS continues its planning to ramp-up and implement technical assistance and capacity-building for providers to implement routine HIV testing in healthcare settings. Because a majority of new cases in San Mateo County are identified through visits to a healthcare provider, there is an increased need to expand the capacity of healthcare sites to implement routine HIV testing. SMCHS has developed staff training on CDC's *Recommendations for HIV Testing in Healthcare Settings* and will provide onsite assistance with HIV-positive disclosures, linkage to care, and partner services. SMCHS will target these services to healthcare settings that are frequent reporters of HIV cases, as well as healthcare settings that are located in geographic areas that are disproportionately impacted by HIV disease. Additionally, these services will also be available to substance use and recovery program sites.

Community awareness in racial/ethnic populations: In San Mateo County, racial/ethnic minorities make up almost three-quarters of newly diagnosed HIV cases (72%). Additionally, people who identify no risk or whose risk is unknown account for almost one-third of all new HIV cases (32%). These statistics converge to identify an increased need for community-level HIV prevention interventions targeting racial/ethnic populations in San Mateo County. SMCHS has developed collaborative relationships with both the African American and Hispanic communities. These relationships will serve as a key in implementing broad-based community awareness activities around HIV prevention and care. Additionally, SMCHS staff's participation in external advisory health committees focused on minority health has provides opportunities to ramp-up HIV prevention activities around HIV awareness days and other community-related events. SMCHS has also worked with the faith-based community to develop a social marketing campaign called, *"Have faith. Get tested!",* which utilizes ministers as community messengers for HIV testing.

Condom distribution: Condom distribution is an essential part of maximizing resources for HIV prevention in a cost effective manner. SMCHS is committed to integrating condom distribution across the continuum of HIV care and prevention services. Additionally, SMCHS disseminates condoms to sentinel distribution sites in areas where there is a disproportionate burden of HIV

disease. The type of facilities that serve as sentinel condom distribution sites include: barber shops, hair and nail salons, adult bookstores, churches, community centers, CBOs, community re-entry programs, alcohol and drug recovery programs, employment centers, day laborer work sites, homeless shelters, etc.

Goals and Objectives/Scalability of Activities

SMCHS has developed goals and objectives to respond to the needs of those with the greatest risk of transmitting or acquiring HIV. SMCHS will ensure that allocations for HIV prevention and care services are in alignment with priorities to meet these objectives. Below are highlights of the goals and objectives that will contribute to attainment of the NHAS. The SMCHS Comprehensive HIV Prevention Plan, a complementary document to this Plan, provides more detail on these objectives.

Reduce new infections in San Mateo County by 25% *(scale up)*

- Expand outreach and testing to MSM
- Expand outreach and testing to heterosexuals who have sex while high on non-injected drugs
- Expand outreach and testing to African Americans
- Expand outreach and testing to Hispanics in highly impacted regions of the county

Increase the percentage of newly diagnosed people linked to care within 3 months to 85% *(scale up)*

- Coordinate linkage to care through healthcare settings, community-based HIV testing, and HIV/STD surveillance reporting

Increase the proportion of HIV-diagnosed gay/bisexual men, African Americans, and Hispanics with undetectable viral load by 20% *(scale up)*

- Coordinate targeted outreach to HIV-diagnosed gay/bisexual men, African Americans, and Hispanics for engagement and retention in HIV primary care
- Conduct targeted PWP activities with gay/bisexual men, African Americans, and Hispanics

The SMCHS HIV Prevention Plan's goals and objectives are in alignment with the NHAS and support collaborative efforts to:

- Reduce new HIV infections
- Reduce HIV-related health disparities
- Increase access to care and optimize health outcomes for PLWHA

Coordination of Service Delivery

San Mateo County currently has a strong coordinated effort between both HIV care and prevention, as they are part of the STD/HIV Program and have joint leadership teams. Additionally, STD screening, surveillance, and treatment bring additional capacity for case-finding, partner services, and linkage to care. HIV prevention and care collaborate closely and have developed protocols for linkage to and retention in care, partner services, and prevention with positives.

SMCHS is strengthening its collaborative efforts with substance use recovery programs. While HIV prevention education and testing is currently provided at many recovery sites, SMCHS will devote more attention and effort to increasing each agency's capacity to implement harm reduction methodologies, wherever possible. Also, SMCHS will work to establish more recovery

sites as sentinel condom distribution sites and provide effective referrals for on-demand HIV testing, HIV testing, group education, and training for recovery program staff

Although SMCHS participates in a variety of multi-disciplinary departmental and external health promotions committees, it will continue to develop a more coordinated effort to plan and document ongoing, targeted community engagement activities to more effectively extend and monitor the impact of HIV prevention and care activities.

Timeline

SMCHS is excited to continue its new collaboration as part of the San Francisco MSA for HIV prevention. This partnership will certainly strengthen HIV prevention and care efforts in the region and result in better services for the entire Bay Area. A detailed timeline for implementation of goals and objectives is included in the SMCHS Comprehensive HIV Prevention Plan.