San Francisco's Integrated Ending the Epidemics Plan

2024 – 2026 STRATEGIES AND ACTIVITIES

Serving as the HRSA/CDC-required integrated plan for the HIV Community Planning Council; SF's local strategy to align with California's Integrated Statewide Strategic Plan for Addressing HIV, HCV, and STIs from 2022-2026; and SF's local Ending the Epidemics plan.

San Francisco
Department of Public Health

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1. Introduction

BACKGROUND

In 2020, San Francisco (SF) received funding from the federal Ending the HIV Epidemic initiative, and in October of that year released its plan entitled ***Ending the Epidemics: Collective Strategies for Addressing HIV, Hepatitis C, and Sexually Transmitted Infections in San Francisco.*** SF's plan laid out an ambitious agenda for ending the syndemic of these three conditions, and this plan paved the way for a number of innovative strategies and activities that rolled out from 2020 through 2024, at which time the federal CDC EHE funding will be folded into cooperative agreements with states and directly funded cities. Concurrently, the California Department of Public Health (CDPH) published its ***Integrated Statewide Strategic Plan for Addressing HIV, HCV, and STIs from 2022 – 2026,*** and invited CA counties to join their efforts by developing locally tailored versions of the State's plan. While developing its strategic plan, CDPH collaborated with HRSA and CDC to allow their plan to fulfill the CDC and HRSA requirement that funded jurisdictions develop an integrated HIV care and prevention plan, and SF signed on to this agreement. In short, this plan serves multiple purposes, helping to streamline the many plans and planning processes that exist, in order to take a holistic, coordinated approach to the syndemic.

This plan:

- Meets CDC and HRSA (both EHE and Ryan White Part A) requirements for an HIV Integrated Plan
- Fulfills CDPH's recommendation that each California county have a local plan that reflects CDPH's strategic plan;
- Outlines SF's strategies and activities to end the epidemics for 2024 – 2026; and
- Informs the priorities for HIV, HCV, and STI-related funding applications for 2024 – 2026.

Ultimately, the purpose of this plan is to provide a roadmap to overcoming inequities in health outcomes in HIV, HCV, and STIs in SF. This plan will be updated at least every 5 years, and more frequently if needed. Each year, SFDPH will provide an update to the HIV Community Planning Council (HCPC) on progress made on the blueprint activities.

HOW THIS PLAN IS ORGANIZED

This plan begins with an overview of the foundational services, programs, and other efforts that are the hallmark of SF's approach to serving communities affected by HIV, HCV, and STIs – in other words, the service infrastructure and signature strategies that have been established over many decades, and what many have come to think of as the "San Francisco model." A high-level overview is offered, because to describe the extensive network of services would take hundreds of pages.

The next section describes the efforts that SF is undertaking and will undertake in the next few years that go above and beyond the core work – bold strategies and activities that aim to make a significant contribution to ending the epidemics. In alignment with CDPH's strategic plan, this section is organized by the social determinants of health (SDoH), because these are the factors that continue to drive new infections and poor health outcomes among

people living with and at risk for HIV, HCV, and STIs. SF cannot end the epidemics without lifting up these root causes and doing what is possible to lessen their impacts on health and wellness.

INPUT AND ENGAGEMENT

Drafts of this plan were shared with the following key stakeholders for input/feedback throughout plan development:

- ETE Steering Committee (October 17, 2023)
- SDFPH ETE Leadership Committee (October 24, 2023)
- SFDPH HIV Working Group (November 13, 2023)
- HCPC Council Affairs Committee (November 14, 2023; April 9, 2024)
- HIV Community Planning Council (HCPC) (November 27, 2023; April 22, 2024)
- Getting to Zero SF Steering Committee (February 12, 2024)
- HIV/AIDS Providers Network (March 1, 2024)
- HIV Housing Workgroup (March 26, 2024)
- End Hep C SF leadership (April 15, 2024)
- Frontline Organizing Group (April 16, 2024)

Input and feedback from these groups helped fill in gaps in the plan, including highlighting the Mayor's Office of Housing and Community Development's (MOHCD) efforts, ensuring that workforce development is inclusive of PLWH who are re-entering the workforce, recommending expansion of partnerships with local SAMHSA-funded programs, and much more.

2. Epidemiology and Priority Populations

EPIDEMIOLOGY OF HIV, HCV, AND STIS IN SAN FRANCISCO

The state of HIV, HCV, and STIs in SF

In the last decade, the landscape of HIV, HCV, and STIs has changed considerably in San Francisco (SF). Advances in treatment and prevention for HIV, HCV, and STIs have impacted the epidemiologic profiles, with some populations experiencing more benefit than others. This phenomenon—where the implementation of new interventions tends to disproportionately benefit people with privilege (e.g., white people, cis men, people with health insurance)—can be largely explained by the social determinants of health affecting those with less privilege. Factors such as lack of housing and income inequality are more pervasive and intense than ever before, resulting in disparities in health outcomes by race/ethnicity, housing status, transmission risk group, gender, and mental health and substance use, neighborhood, and other demographic and behavioral factors.

Declines in new HIV diagnoses and increases in HIV viral suppression rates, HCV cures for thousands of SF residents, and innovations in STI prevention are successes to be celebrated. In many ways, the most challenging work remains, because it requires going beyond the simple provision of services to addressing the deeply complex issues of poverty, racism, homophobia and transphobia, access to care, mental health and substance use, incarceration, and much more. An added challenge is that declines in the local and state economies and a large budget deficit are leading to reductions in funding for social services. These factors demand an increased focus on person-centered, integrated services, increased innovation, and a social determinants of health-informed approach.

The need for a syndemic approach

Syndemics are epidemics of diseases or health conditions that interact with each other, exacerbating their adverse effects on communities that face inequities,[1] and are often driven by the same upstream social determinants of health. Given the overlap in the populations experiencing disparities in HIV, HCV and STI outcomes, as well as the overlap in transmission routes of HIV, HCV, and STIs, strategies to address these epidemics must be coordinated and integrated. The interconnectedness of HIV, HCV, and STIs, and the shared social determinants of health affecting their health outcomes, including substance use, mental health,[2] homelessness, poverty, racism, and homophobia, among others, demand a syndemic framework and a fully integrated system of care.

The next several pages summarize the current status of HIV, HCV, and STIs, with an emphasis on persistent disparities that could be addressed through a syndemic approach.

[1] https://www.cdc.gov/hiv/pdf/division-of-hiv-prevention/cdc-hiv-dhap-external-strategic-plan-2022.pdf (p. 11)

[2] Substance use and mental health are medical disorders, which makes them different than the other SDoH. Like the other SDoH though, they are upstream factors (with social and environmental components as well as medical) that impact HIV/HCV/STI transmission and health outcomes.

HIV

Background

As a result of hard-fought accomplishments in prevention, care, and treatment services informed by a robust HIV surveillance system, SF is on track to achieve its goal to 'Get to Zero': zero new HIV infections; zero HIV deaths; and zero HIV stigma. Over the last decade, SF has implemented a data-driven, high impact prevention (HIP) strategy, with resulting significant, steady reductions in new HIV diagnoses and increasing linkages to care and viral suppression among people living with HIV (PLWH) (Exhibit 1).

As shown in Exhibit 2, in 2019, new HIV diagnoses dropped below 200 to 179, a 67% decrease since 2006.[3] However, in 2021, for the first time in more than a decade, new HIV diagnoses increased (147 to 166), likely due to delayed diagnoses during the COVID-19 pandemic. In 2022, new diagnoses remained essentially level at 157.[1]

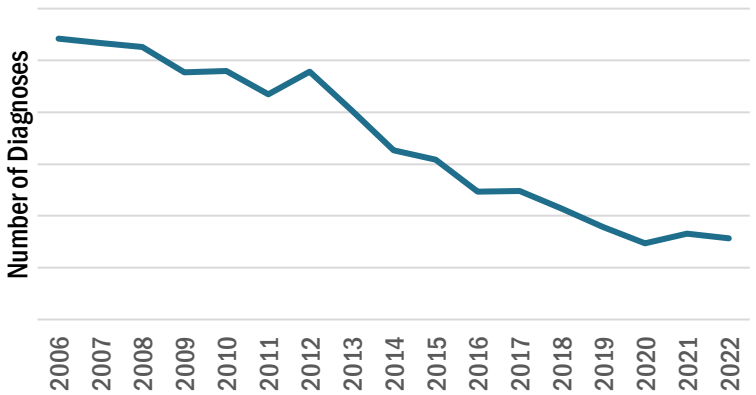
Exhibit 1: Key milestones in SF's 'Getting to Zero' Efforts

- New HIV diagnoses have decreased 71% since 2006; no children <13 years have been diagnosed since 2005.
- Three-year survival rates for people with stage 3 HIV have nearly quadrupled—88% from 2012-21, vs. 23% from 1980-89.
- HIV-related deaths are making up smaller proportions of all deaths; 26% of deaths in SF were HIV-related from 2018-2021, versus 41% of deaths from 2010-2013.
- Most HIV-related deaths are occurring among people ages 60 and older.
- PLWH are aging, with 2/3 of PLWH in SF 50 years and older and 30% 60 years and older.
- 97% of PLWH are aware of their HIV status.
- 90% of people newly diagnosed with HIV in 2022 were linked to care within 1 month of diagnosis; 80% of those newly diagnosed were virally suppressed within 1 year.
- Linkage to care is typically fast; from 2018-2021 the median time between diagnosis and first care visit was 1 day, and the median time to ART initiation was 0 days.

HIV Disparities and Health Inequities

Despite promising trends, HIV-related disparities persist in SF with respect to diagnosis and viral suppression rates. Populations experiencing HIV-related disparities include people who are Black/African American, people who are Latina/o/e/x, gay men and other men who have sex with men (MSM), trans women, people who inject drugs (PWID), and people experiencing homelessness (PEH). Select examples are shown in Exhibit 3, next page.

Exhibit 2. New HIV diagnoses in SF have decreased 70% (2006-22)



[3]SFDPH HIV Epidemiology Annual Report 2022: https://www.sfdph.org/dph/comupg/oprograms/hivepisec/hivepisecreports.aspSFDPH

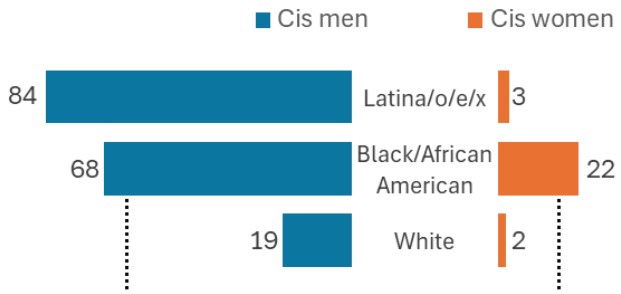
Summary of HIV Epidemiology

The overall decline in new HIV diagnoses and improvements in HIV care outcomes are encouraging. However, persistent disparities by race/ethnicity, housing status, transmission risk group, gender, and mental health and substance use factors highlight the critical need to address the social determinants of health.

Exhibit 3. Select examples of persistent HIV-related disparities in SF*

Among the SF populations with the highest numbers of HIV diagnosis, Latina/o/e/x and Black/African American cis men and Black/African American cis women experience higher rates of new HIV diagnosis, compared to white cis men and women.

HIV diagnosis rates per 100,000 shown below (2022)



Black/African American San Franciscans experience high HIV mortality :

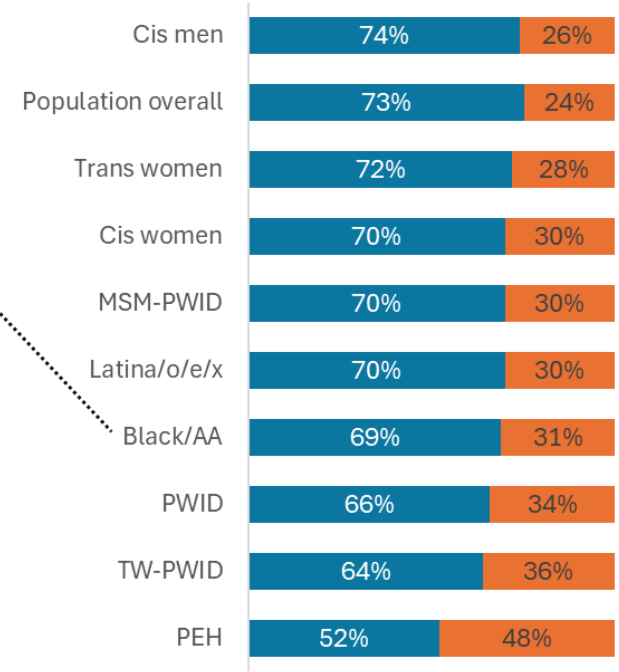
- Mortality among Black cis men was double the rate of white cis men and nearly triple that of Latino/e/x cis men in 2021.
- Mortality among Black cis women was 4.1x that of Latina/e/x cis women and 5.9x that of white cis women in 2021.

- 19% of new HIV diagnoses were among **PWID** in 2022, despite PWID making up ~3% of SF residents.
- Similarly, 17% of new diagnoses were among **PEH** in 2022, despite PEH making up <1% of SF residents.

- **MSM (including PWID)** made up 72% of new HIV diagnoses in 2022, despite making up 7.8% of the SF population.
- **Trans women** made up 3% of new HIV diagnoses in 2022, despite making up 0.1% of the SF population.

Viral suppression rates vary by race/ethnicity, gender identity, and injection drug use.

Percent virally suppressed shown below, 2022 (some groups overlap)



***PWID** = people who inject drugs; **PEH** = people experiencing homelessness; **MSM** = men who have sex with men; **AA** = African Americans; **TW** = trans women

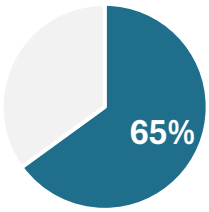
HEPATITIS C (HCV)

Background

In 2019, researchers from *End Hep C SF*—SF's collective impact HCV elimination initiative—estimated that 22,585 residents of SF (2.6% of all SF residents) had antibodies to HCV. This is higher than the U.S. seroprevalence estimate of 1.7%. *End Hep C SF* also estimated that 11,582 SF residents (1.3%) still have untreated, active HCV infection, which can transmit to others and progress towards liver disease.

Before 2014, HCV treatment was highly toxic, required almost a year to complete, and had a very low success rate. As a result, many people who knew they were living with HCV chose to forgo treatment options, risking severe liver damage from chronic HCV infection. Today, curative treatment for HCV is now widely available in SF, easy to take with short treatment regimens, and has exceptionally high cure rates. Thousands have been cured since the advent of the new treatments, but those with the greatest barriers to care continue to experience disparities in access to these treatments and are also disproportionately represented among HCV cases. Therefore, identifying and addressing remaining disparities is critical to equitable HCV elimination in SF.

Key to improving HCV treatment rates is ensuring that people living with HCV are aware of their status and linked to care. In 2022, 62.4% of chronic HCV cases newly reported to the health department had positive HCV antibody tests *without* confirmation of a positive HCV RNA test that would indicate current HCV infection. Reporting of both negative and positive HCV RNA tests by labs (currently being integrated into laboratory reporting processes) is a critical step towards better understanding the epidemiology of HCV in SF, and in guiding programmatic efforts to support linkage to care and curative treatment to those with confirmed, chronic HCV.



In 2022, the majority of SF's reported HCV antibody positive cases were **not confirmed** with an HCV RNA test.

Notably, people with HIV are disproportionately impacted by HCV. In SF, it is estimated that 11.5% of PLWH are co-infected with HCV, with co-infection particularly high among MSM and PWID. Despite successful citywide efforts to increase HCV treatment uptake, there are still an estimated 500 to 1,000 San Franciscans who are co-infected with HIV/HCV who need HCV treatment. This includes approximately 130 people who are SF Health Network (SFHN) patients.

HCV Disparities and Health Inequities

Groups of people less likely to be engaged in medical care account for most people living with HCV in SF. Similar to HIV, the SF populations most disproportionately impacted by HCV include PWID, trans women, MSM, and people who are Black/African American (Exhibit 4, next page).

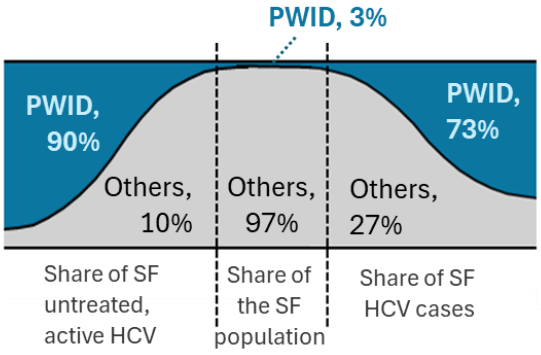
Summary of HCV Epidemiology

HCV elimination in SF is a reachable goal, given curative treatments, but barriers to treatment access must be addressed. SF's HCV efforts prioritize reaching and effectively serving populations with the greatest disparities and highest barriers to treatment and cure. People co-infected with HCV and HIV are a priority, as people who are co-infected are more likely to experience adverse health consequences of HCV compared to those who are not also living with HIV.

*Exhibit 4. Select examples of HCV-related disparities in SF**

Many SF populations experience a disproportionate burden of HCV.

- An estimated **63% of PWID** (10,468 people) have untreated active HCV infection in SF.
- Shown below, PWID make up a disproportionate percent of untreated, active HCV infections (left) and HCV cases overall (right), compared to their population size (middle).



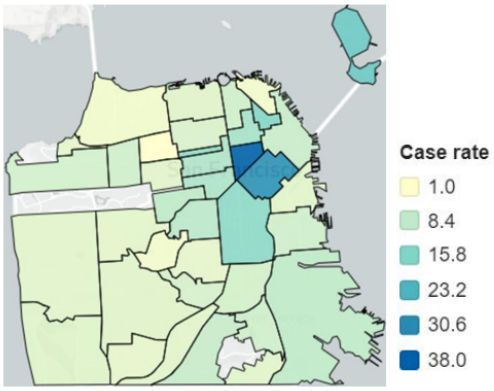
- **An estimated 57% of low SES trans women** have untreated active HCV infections; these women account for 1.6% of untreated active infections despite making up 0.1% of the total SF population.
- 70% of SF chronic HCV cases reported to SFDPH in 2022 were among **men.** Among men, **MSM** are estimated to account for 11.7% of HCV cases and only 7.8% of the population; 1% of cases are estimated to still have untreated active infections.
- **People who are Black/African American** comprise 22.5% of all SF chronic HCV cases reported to SFDPH in 2022 but only 4.9% of the SF population.

Age trends in HCV

Most HCV cases in SF are older; however, younger people (<45 years old) are increasingly represented:

- Among all cases reported to SFDPH in 2022, 46.4% of all cases were born between 1945 and 1965 ("baby boomers"), compared to 32.8% of newly reported cases in 2022.
- Newly reported cases in 2022 were more likely to be born after 1984 when compared to all cases reported in 2022 (38 years or younger). The proportion of newly reported cases born after 1984 was 30.9%, compared to only 20.4% of all cases reported in 2022.

Neighborhoods with lowest median income have higher HCV rates.

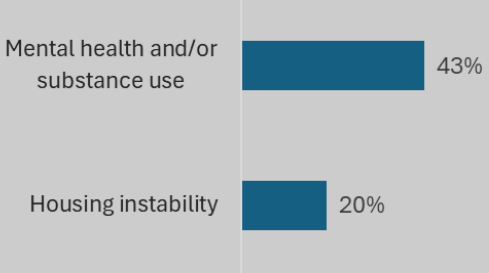


The rate of newly reported cases in 2022 was highest for the Tenderloin, South of Market, and Treasure Island neighborhoods. The Tenderloin and Treasure Island neighborhoods have the second and third highest poverty rates in SF, respectively.

Top barriers to HCV care among people coinfected with HIV and HCV

Among people coinfected with HIV and HCV, those who experience the highest barriers to HCV care and cure often have **co-occurring medical and mental health diagnoses, and are often experiencing housing instability and other socioeconomic challenges**.

Percent of people coinfected with HIV/HCV reporting the barrier at Zuckerberg San Francisco General Hospital HIV/AIDS clinic



***PWID** = people who inject drugs; **SES** = socioeconomic status; **MSM** = men who have sex with men; **PLWH** = people living with HIV

SEXUALLY TRANSMITTED INFECTIONS

Background

SF has higher chlamydia, gonorrhea, and early syphilis rates compared to all of California and the U.S., as well as Los Angeles and New York City. From 2008 to 2018, while the number of new HIV diagnoses declined by over 60%, the rate of chlamydia increased 244%, the rate of gonorrhea increased 195%, and the rate of early syphilis increased 157%. However, in recent years (2017-2022), SF has seen decreased annual incidence rates for chlamydia, gonorrhea, and early syphilis. Between 2019-2022, citywide chlamydia rates declined by 32%, gonorrhea by 7%, and early syphilis by 26%, likely related to changes in sexual behaviors and disruptions in access to health services during the COVID-19 pandemic.

In San Francisco, cis men make up 95% of new early syphilis cases,[1] and about two-thirds of new early syphilis cases occur among gay, bi, and other men who have sex with men (MSM).[5] However, **syphilis rates have been increasing rapidly among cis women in San Francisco,** mirroring a marked increase in reported cases of syphilis among women and congenital syphilis both nationally and in California. From 2017–2021, syphilis diagnoses among cis women in San Francisco increased by 200% (1582 to 1642) and **CS cases increased 333%** (13 cases) compared to the prior five-year period (3 cases). SFDPH focused efforts on identifying and prioritizing pregnant women with syphilis, and on better understanding the populations most impacted by female syphilis.

Exhibit 5: Explaining STI rises (2008-18)

Paradoxically, increased STIs may have been driven by gains in HIV prevention. Decreases in HIV in SF are the result of scaled-up HIV testing, promotion of early and widespread HIV treatment, a strong linkage to care program, and access to pre-exposure prophylaxis (PrEP). As taking PrEP if HIV-negative or maintaining an undetectable HIV viral load if living with HIV can prevent sexual transmission of HIV, condom use has declined, facilitating transmission of gonorrhea, chlamydia, and syphilis.

Exhibit 6: Increases in syphilis in cis women and congenital syphilis

Female syphilis cases rose from 114 to 184 between 2018-21 and then plateaued from 2021-24. Among 186 female syphilis cases in 2022, 18 were known to be pregnant, including 6 who were experiencing homelessness, 4 who reported methamphetamine use, and 1 who reported heroin use. Of the 16 pregnancy outcomes known, 9 averted congenital syphilis, 4 resulted in spontaneous or therapeutic abortion, and 3 resulted in congenital syphilis.

Since the national mpox outbreak in 2022, SF has recorded 940 total cases as of 4/12/24[4] and the highest cumulative mpox case rate in the state. Cases have declined overall since 2022 (842 cases), with 91 cases reported in 2023; 96% of cases have been among men and the majority reported sex with other men. Cases have also disproportionately impacted people who are Hispanic/Latina/o/e/x and white.

The effects of doxycycline post-exposure prophylaxis (doxy-PEP) for STI prevention on rates of STIs are being monitored. Among MSM, chlamydia and syphilis cases have declined from 2022 to the end of 2023 - since the introduction of doxy-PEP in the last quarter of 2022. However, the number of chlamydia cases among cis women (for whom doxy-PEP is not recommended) have been increasing over the same time period.

Given the relatively high incidence of STIs in SF, SFDPH is prioritizing populations disproportionately impacted (Exhibit 7, next page), including: 1) gay, bisexual, and other MSM; 2) adolescents and young adults, particularly those who are BIPOC; 3) trans persons; and 4) cis women of reproductive age who are at risk for syphilis infection

[4] https://www.sf.gov/data/mpox-case-counts#cumulative-cases

(and therefore newborns with congenital syphilis). Across all four of these populations, people who are Black/African American experience higher rates of STIs than any other racial/ethnic group and are therefore included as a prioritized population.

Summary of STI Epidemiology

- Syphilis rates are still high among cis women. Congenital syphilis is of concern and complex to address, given its overlap with substance use and homelessness among pregnant people.
- Declines in chlamydia, gonorrhea, and syphilis among MSM since the emergence of mpox and doxy-PEP are being evaluated.
- An uptick in mpox cases since July 2023 reflects the need for ongoing vaccine promotion and education.
- Persistent STI disparities among adolescents and young adults requires continued efforts to promote screening and education, particularly among BIPOC youth.

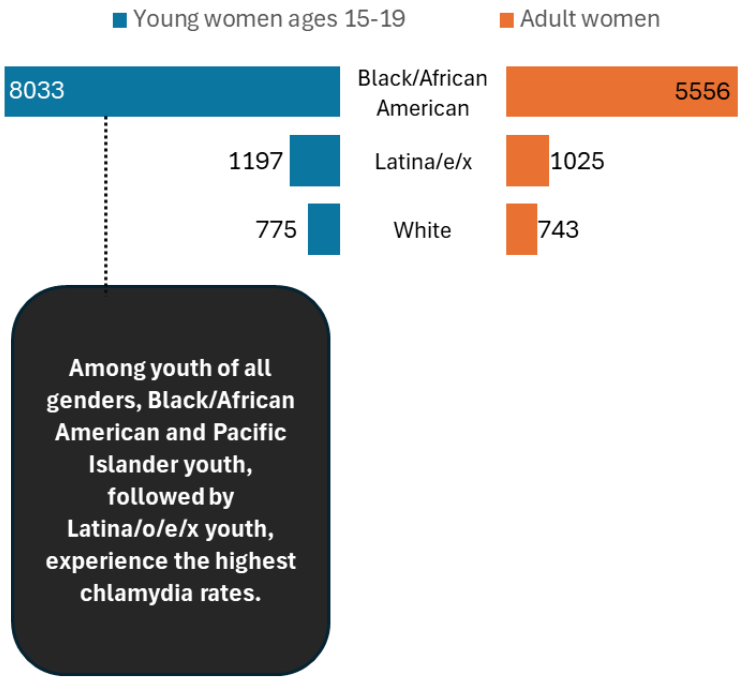
Exhibit 7. Select examples of STI-related disparities in SF

Among populations with at least 200 reported cases of chlamydia or gonorrhea and 100 cases of early syphilis in 2022, **Black/African American and Latina/o/e/x people experienced the highest rates of all three of these STIs.**

- **Gay men and other men who have sex with men** have the highest prevalence rates of gonorrhea, chlamydia, and early syphilis compared to other transmission groups.
- **Trans women** also have very high rates of STIs compared to other San Francisco residents; at SF City Clinic, STI positivity among trans women is similar to positivity among men who have sex men.

Chlamydia rates among women are extremely high among those who are Black/African American, followed by those who are Latina/e/x, compared to those who are white.

Chlamydia rates per 100,000 shown below (2022)



PRIORITY POPULATIONS

A key rationale for an integrated approach to HIV, HCV, and STIs is the strong (but not perfect) overlap in affected populations (Exhibit 8), because it creates numerous opportunities for programs to offer a comprehensive suite of prevention, testing, care, and treatment services that promote sexual health, harm reduction, and overdose prevention. Populations with **two or more** disparities in key epidemiologic indicators are deemed priority populations for ending the epidemics. Three common epidemiologic indicators of disparities are:

1. **High prevalence**, meaning that the percentage of people in the given population who are affected by HIV, HCV, or STIs is higher than for others. This indicator represents the disproportionate burden of disease carried by a population.

2. **Account for a disproportionate number of new infections**, meaning that the number of people newly acquiring HIV, HCV, or STIs is higher in a given population than would be expected given their representation in the overall SF population. For example, if there were 150 people in all of SF, and two-thirds of the population (n=100) was from population X and one-third (n=50) from population Y, you would expect that, all things being equal, population X would experience two-thirds of new infections and population Y one-third. If population X experienced more than two-thirds of new infections (or population Y experienced more than one-third of new infections), this would be considered a disparity.

3. **Less likely to be virally suppressed or experience other positive health-related outcomes.**

It is important to note that the highlighted priority populations are not the only ones in need of services. Limited data and/or small numbers for some populations, such as Native Americans, make it difficult to assess disparities that might exist. In addition, services are still needed for populations with low HIV/HCV/STI incidence and prevalence, to ensure that the low rates are sustained and to ensure equitable access to services for all. For example, while HCV and HIV prevalence and incidence are relatively low among youth, there are high rates of STIs among youth of color, and programs for youth are key opportunities for health education and support services. People who are incarcerated are also a critical population, although not separately highlighted as a priority population in this plan because PEH, PWU/ID, and Blacks/African Americans are disproportionately represented among this group. Lastly, Exhibit 8 does not represent the multiple intersectionalities of identity and experience, nor does it reflect the complexities of differences in health outcomes among population subgroups or the fact that a population can have positive outcomes with respect to some indicators and poorer outcomes with respect to others. All of these factors underscore the importance of tailored interventions that are data-informed, but also informed by community needs and experience.

Exhibit 8: Priority Populations for Ending the Epidemics

Population	HIV	HCV	STI
Blacks/African Americans	• Account for a disproportionate number of new infections • Less likely to be on PrEP or achieve viral suppression	• Account for a disproportionate number of new infections	• Account for a disproportionate number of new infections • B/AA youth: High prevalence (GC, CT)
Latina/o/e/x	• Account for a disproportionate number of new infections • Less likely to achieve viral suppression		• Latina/o/e/x youth: High prevalence (GC, CT)
Trans women	• High prevalence • Account for a disproportionate number of new infections	• High prevalence • Account for a disproportionate number of new infections	• High prevalence
PWU/ID	• High prevalence • Account for a disproportionate number of new infections	• High prevalence • Account for a disproportionate number of new infections	• Account for a disproportionate number of female syphilis cases
PEH	• Account for a disproportionate number of new infections • Less likely to be on PrEP or achieve viral suppression		• Account for a disproportionate number of female syphilis cases
MSM	• High prevalence	• Account for a disproportionate number of new infections	• High prevalence (GC, CT, syphilis, mpox) • Account for a disproportionate number of new infections
Cis women	• Less likely to be on PrEP or achieve viral suppression		• Vertical transmission risk among cis women of reproductive age (syphilis)

3. Foundational Efforts Addressing HIV, HCV, and STIs

SF'S APPROACH

Integrated services and whole-person care approach

Given the overlap in the populations experiencing persistent disparities in SF, whenever appropriate, all three epidemics are approached jointly to ensure a whole-person care approach to HIV, HCV, and STI prevention, care, and treatment. This aligns with key values and principles in the SF EtE Plan.

1) **Integration of HIV, HCV, and STI prevention, care and treatment services, and harm reduction and overdose prevention.** Given the interconnectedness of these diseases and the broader drivers of the disparities such as substance use, mental health disorders, homelessness, poverty, racism, homophobia, sexism, and transphobia, to succeed at ending the epidemics, SF has committed to fully integrated systems and programs whenever appropriate that are person-, not disease-centered.
2) **Whole person care.** In the broadest sense, whole person care is predicated on the understanding that the best way to care for people with complex needs is to consider the full range of those needs – including physical, mental, social, and economic needs. SF's whole person care approach builds on an "ecosystem of care" model that emphasizes care coordination across medical, mental health, substance use, housing, and social needs.

An ideal integrated service model allows a person to get support for all their health and social service needs, whether it's HIV/HCV/STI testing or care, or, for example, other support for quitting smoking, benefits navigation, or substance use counseling. With this approach, the clients' experience and health outcomes are improved. SF's approach to integrated services and coordinated strategies is exemplified by Health Access Points and the Centers of Excellence.

SF's Foundational HIV/HCV/STI Efforts: Setting the Stage for Ending the Epidemics

The EtE initiative focuses on scaling up and implementing innovations in four science-based strategies—diagnosis, treat, prevent and respond—that together can end the HIV/HCV/STI epidemics. Starting on p. 18, SF's plans for scaling and innovating services are described. However, it is critically important to note that these efforts are layered on top of a strong foundation of strategically developed HIV, HCV, and STI services built over decades (in the case of HIV and STIs) and more recently (HCV). This section describes this foundation, its evolution, and how that groundwork is acting as a springboard to end the epidemics. The diagnose, treat, prevent, and respond pillars are a useful framework, but many of the existing foundational efforts cut across the pillars because many programs in SF already offer integrated testing, treatment, and prevention services. For the purposes of this plan, the services are described in the most relevant pillar.

Pillar 1: Diagnose

Over the last decade, SF's HIV testing providers—in both community and clinical settings—helped normalize HIV testing as part of regular health maintenance, especially among the most impacted communities, contributing

significantly to 97% status awareness among PLWH in SF. Chlamydia, gonorrhea, and syphilis testing has been available at SF City Clinic, in public and private primary care settings, and some community-based sites, but not all HIV testing locations offer STI testing. Community-based HCV testing, particularly for PWID and people experiencing homelessness, has scaled up dramatically since the advent of direct-active antivirals for HCV treatment, but requires the capacity for wide and deep reach into communities at risk, many of which do not access health care in traditional settings, or at all. Given the overlapping epidemics and risk factors, siloed testing represents lost opportunities for diagnosis, treatment, and education. SF aims to expand integrated HIV/HCV/STI testing in 2024-2026.

The infrastructure built to support CLIA-waived rapid HIV community-based testing and to routinize HIV screening in primary care and other clinical settings serving priority populations represents a solid foundation to achieve this aim. Successful integrated testing already exists at SF City Clinic and some other locations. This plan describes a number of activities to scale up HIV/HCV/STI integrated testing in the context of a broader effort to address the social determinants of health. For example, the new Health Access Points, which are tailored to specific populations experiencing disparities (described under Pillar 3 and throughout this plan) are required to offer integrated testing, and SFDPH's public health detailing program will be working to integrate HCV and STI testing in clinical settings where it makes sense given the population served.

Other innovative efforts identified for scale-up include pharmacy-based integrated testing, mobile testing, self-testing, and integrated testing in non-traditional settings where syndemic-affected populations can be reached, such as supportive housing, jails, and substance use treatment programs.

Pillar 2: Treat

HIV

SF is home to one of the first outpatient HIV clinics in the nation (ZSFG Ward 86). It was also the first city to establish a policy that ART should be universally offered to people upon HIV diagnosis, and is widely known for its rapid adoption of new advances in treatment. PHAST (Positive Health Access to Services and Treatment) is an interdisciplinary team at Ward 86 staffed by a registered nurse, clinician, and social worker who offer low-barrier access to RAPID ART and linkage to care support to patients coming into Ward 86 after a new HIV diagnosis or those re-engaging in care after being out of care. The PHAST team supports over 500 patients a year, primarily priority populations described above, by providing expedited clinic intake, nursing care coordination, and psychosocial stabilization to patients vulnerable to being lost to follow-up due to high rates of homelessness, mental illness, and active substance use. The PHAST model addresses the social determinants of patient health along with addressing the barriers to care.

SF has exceptional capacity for providing state-of-the-art HIV treatment, including through the Ryan White-funded HIV Centers of Excellence (CoEs). CoEs were created to serve severe-need clients and special target populations. The CoE model establishes primary medical care at the center of an integrated service delivery model offering integrated access to both primary medical care and critical services. At a minimum CoE must provide: 1) primary medical care, 2) medical case management, 3) psychiatric assessment and psychiatric medication monitoring, 4) treatment adherence and medication assistance, 5) outpatient mental health treatment, and 6) substance use assessment, counseling, and referral. Each multidisciplinary CoE, while open to all, is customized to serve a particular population that has unique or disproportionate barriers to care, needs additional or unique services, or requires a special level of expertise to maintain them in care:

- **Homeless Aging and Long-term Survivors (HALT) Center of Excellence**

Focuses on services for people experiencing housing instability and homelessness; men who have sex with men; Latina, African American and trans women; and immigrants, with a focus on undocumented Spanish-speaking persons.

- **HIV Integrated Services (HIV-IS)**
  Focuses on the coordination of care for HIV-positive incarcerated and post-release people and serves the SF County jails.
- **Mission Center of Excellence**
  Focuses on services for Latino/Latina populations, including monolingual Spanish speakers and immigrants, regardless of legal status.
- **Black Health Center of Excellence**
  Focuses on services for underserved and uninsured Black/African Americans, including cis women and trans women.
- **Tenderloin Area Center of Excellence**
  Focuses on homeless and marginally housed persons, active substance users; transgender persons, Asian/Pacific Islander groups, and prison populations.
- **Women's Center of Excellence**
  Focuses on underserved and severe-need cis and transgender women.

There is also a vast network of services beyond the CoEs for people living with HIV, including job training, housing, benefits counseling, and much more.

SFDPH's LINCS (Linkage, Integration, Navigation and Comprehensive Services) program is also a core part of SF's foundation for HIV treatment. LINCS serves people newly diagnosed with HIV and prioritized individuals who are not-in-care, including those who access care intermittently, and supports them to engage in care. All people who newly test positive for HIV in SF are offered linkage to care and partner services through LINCS. LINCS, which is housed at SF City Clinic, maintains strong partnerships with HIV care sites throughout SF. One of LINCS' closest partnerships is with the PHAST team, which as mentioned above supports PLWH in accessing expedited care and RAPID ART. The partnerships with PHAST and other clinical care sites allow for successful linkage and engagement by lowering barriers to care and offering care coordination, system and insurance navigation, and appointment tracking.

In summary, PLWH experience many barriers to HIV care engagement in SF, especially barriers related to the social determinants of health, but due in part to numerous high-quality, culturally tailored treatment options, SF has linkage to care and viral suppression rates that are higher than for CA and the U.S.

HCV

With the advent of direct-acting antiretrovirals in 2015, HCV became treatable in the primary care setting, whereas before it could only be treated in specialty settings (such as in liver clinics or by hepatologists). Shortly thereafter, SFDPH's primary care providers were offered training to treat HCV, and a clinical consultation line was established. HCV curative treatment is covered by Medi-Cal. This extraordinary medical advance made it possible to envision an end to HCV in SF, and in 2016, the End Hep C SF collective impact initiative was born. This group has engaged in advocacy, fundraising, provider training, research, and service provision to take advantage of this historic opportunity to eliminate HCV in SF. End Hep C SF began an HCV navigator program to link people to treatment, which is still in place today. LINCS provides navigation to HIV/HCV-coinfected patients. A major gap is the provision of HCV treatment in the jail setting, because incarcerated people do not retain Medi-Cal while in jail, and the City currently only covers the cost of HCV treatment during incarceration for a limited number of people

each year; thus, there has been a dedicated jail health navigator for many years who works to link people to treatment upon release.

STIs

With SF's high rates of chlamydia, gonorrhea, and syphilis, easy access to diagnosis and treatment is a critical prevention strategy. SF City Clinic, SF's only municipal STI clinic, is a nationally recognized center of excellence in the provision of quality STI clinical services and serves as a critical access point for low-barrier, confidential, and culturally sensitive clinical STI diagnostics, prevention, and treatment, in addition to offering family planning, HIV care, PEP, and PrEP. STI diagnosis and treatment is also available in primary care settings in SF and at many CBOs. STIs have increased among MSM, making easy access to diagnosis and treatment critical. SF's collaboration with TakeMeHome, a national HIV/STI self-testing program, and doxycycline PEP (doxy-PEP), which can be taken after sex to prevent bacterial STIs, are two key efforts that have already begun and will scale up over the next several years.

Pillar 3: Prevent

In the decades prior to U=U[5] and PrEP, SF's primary approach to HIV prevention involved providing health education and risk reduction to people at risk for HIV as well as people already living with HIV. In the early 2010s, we learned that HIV is virtually untransmissible if a person with HIV is virally suppressed or a person without HIV is on PrEP, and this was a game changer for HIV prevention. Since then, SF has invested heavily in universal and rapid HIV ART, PrEP, and HIV testing so people can learn their HIV status early on to improve outcomes. The results can be clearly seen with the significant decline in new diagnoses between 2012 and 2022. Similar treatment and testing strategies are also being heavily deployed throughout SF for HCV and STIs.

Syringe access and disposal and condom access continue to play a significant role in the HIV prevention landscape, with syringe access also a key HCV prevention strategy and condoms also protective for STIs. SF services aim to be non-stigmatizing, sex-positive, and harm reduction-focused.

In 2023, SFDPH implemented a new service model as part of the shift to a syndemic approach using an SDoH lens: Health Access Points (HAPs). The HAPs, funded and overseen by the CHEP Branch, are integrated low-barrier HIV/HCV/STI service models, where each HAP delivers services for a specific priority population—similar to the CoE model for care services. Each HAP is required to provide integrated testing, linkage to PrEP, HIV/HCV/STI treatment, harm reduction and overdose prevention services, health education, and referrals to services to meet basic needs (e.g., food, housing). The goal is to grow the HAPs into fully functioning "one-stop shops." The HAPs are:

- LOTUS, serving Asians & Pacific Islanders
- Umoja, serving Blacks/African Americans
- Latina/o/e/x HAP
- MSM HAP
- The Lobby, serving PWUD
- Transitional age youth HAP
- STAHR, serving trans women

[5] U=U means undetectable=untransmissible, a phrase that is used to denote the fact that studies have demonstrated that the risk of sexual HIV transmission is nearly 0 when the partner with HIV is virally suppressed.

Pillar 4: Respond

SFDPH is well-prepared to identify and respond to HIV transmission clusters and outbreaks. SFDPH offers partner services to all individuals newly diagnosed with HIV. This service includes assistance with notifying partners and linking them to testing, prevention and treatment if needed. Partner services can aid in the identification of epidemiologically linked or location-based clusters. SFDPH uses molecular HIV surveillance (MHS) to identify clusters of patients who have similar HIV genotypes. Large and closely connected clusters are reviewed to ensure that all individuals in the cluster are linked to care. SFDPH proactively meets with communities and organizations to keep them informed on MHS activities. This is especially important, given past and present harms committed by our medical, legal, and immigration systems, to address perceptions and respond to concerns that such activities could pose risks. In addition, SFDPH has processes in place to identify and reach out to people diagnosed with HIV who do not have recent evidence of medical care, such as a viral load test, in order to offer them linkage to care. Partner services are also important as a component of STI prevention and response. SFDPH offers partner services to prioritized patients with syphilis, as well as to patients with antibiotic-resistant gonorrhea.

4. Ending the Epidemics Plan

The SDoH have a disproportionate impact on BIPOC, economically fragile, and other vulnerable populations and drive the inequities in new infections and health outcomes for HIV, HCV, and STIs. For this reason, the SDoH are central to SF's ending the epidemics strategy, and therefore this plan is organized around that framework.

The six SDoH addressed in this plan are pictured below. Each SDoH has a section. The first page of the section is an introduction, describing the SF context, with SF's strategies listed on the bottom half of the page. The subsequent pages are a single table listing SF's activities related to that SDoH. The first column of the table lists the strategies related to each activity – including strategies that are part of other SDoH sections. This was necessary because the SDoH and therefore the activities are strongly interrelated. The *Related Strategies* column uses the SDoH abbreviations shown underneath the image below.

Racial Equity	Housing First	Health Access For All	Mental Health and Substance Use	Economic Justice	Stigma
					
RE	**HF**	**HAFA**	**MHSU**	**EJ**	**SF**

Lastly, the activities listed are either implemented or funded by SFDPH, unless another organization is listed at the end of the activity in blue highlight.

Introduction

Inextricably linked to the stark racial disparities in HIV, HCV, and STIs in SF is the structural racism embedded in our systems and services, which exclude communities of color from economic opportunities, increasing their vulnerability and preventing them from experiencing optimal health. Structural racism persists because our systems were fundamentally, and in many cases intentionally, designed to benefit white people and to harm people of color. For example, the practice of redlining, in which neighborhoods where Blacks/African Americans (B/AA) lived were systematically denied financial lending opportunities. The effects of this practice were pervasive and severe; cutting off these neighborhoods resulted in reduced economic mobility for residents, spawning a cycle of intergenerational poverty, that today manifests as a stark wealth and income gap between B/AA San Franciscans and other groups. Systems designed to penalize immigrants, particularly Latina/o/e/x immigrants and other immigrants of color, represent barriers to accessing care, for fear that they may get deported and permanently separated from their family. The increase in hate crimes perpetrated against SF's A&PI residents in the wake of COVID-19 is yet another example of an unacceptable status quo. These realities represent chronic stressors that people of color must deal with, not to mention the stress and trauma resulting from the multitude of microaggressions they face in daily interactions, and an unimaginable host of other unjust circumstances from police brutality to inferior educational opportunities. It is no surprise that health outcomes across nearly all diseases are poorer among people of color.

The HIV, HCV, and STI sector, through thoughtful planning and implementation of services, is well-poised to break down barriers to access that cut across racial lines. Key strategies include transforming the composition of the workforce by increasing BIPOC representation, ensuring that funding and resources are allocated based on data and with an equity focus, and community engagement in planning and services delivery.

San Francisco Racial Equity Strategies

(see also *Economic Justice*)

- ✓ **Strategy 1: Leadership and Workforce Development**
  Expand pathways and workforce development initiatives to increase the proportion of BIPOC public health staff, leadership, and administrators within SFDPH and funded HIV/HCV/STI community-based organizations.
- ✓ **Strategy 2: Racial and Ethnic Data Collection and Stratification**
  Identify, collect, analyze, and publicly share data that reflects the specific trends, needs, and outcomes of HIV, HCV, and STIs for BIPOC communities, to inform resource allocation and identify community-based strategies and solutions.
- ✓ **Strategy 3: Equitable Distribution of Funding and Resources**
  Review SFDPH HIV/HCV/STI policies, practices, and program decisions, such as processes related to contracts and budgets, with a racial justice lens, to advance equitable delivery of resources and opportunities to BIPOC.
- ✓ **Strategy 4: Community Engagement**
  Forge strategic partnerships to ensure more diverse public outreach, involvement, and engagement processes to reframe the structure, funding, and policies of HIV, HCV, and/or STI services and messaging to all Californians.
- ✓ **Strategy 5: Racial and Social Justice Training**
  Implement capacity building and training opportunities and requirements for SFDPH and its funded HIV, HCV, and STI service providers, to strengthen out movement towards achieving cultural humility, equity, and racial justice in our prevention, testing, treatment, and care services.

Social Determinant of Health **RACIAL EQUITY**				
Related Strategy(ies)	**Activities**	**2024**	**2025**	**2026 & beyond**
RE1 EJ1 EJ3	**New Deputy Director of Workforce Development.** Strengthen SFDPH's workforce planning, systems, processes, and policies to improve hiring, retention, and training, under the leadership of a new permanent Deputy Director of Workforce Development for the SFDPH Population Health Division (initially funded through the CDC Project INVEST grant). This position will lead and collaborate with a Population Health Division-wide workforce development working group to promote creative options for pathways to new positions within SFDPH (e.g., short-term "residencies" in other branches/divisions), strengthen existing staff well-being programs, launch and maintain a leadership development fund for community health and public health leaders, and start a community of practice for Community Health Workers.	X	X	X
RE1	**Coaching and leadership development at SF City Clinic.** Develop a coaching and leadership development initiative focused on building leadership capacity among mid-level BIPOC managers.	X		
RE1 EJ1 EJ2 EJ4	**Annual conference/training for frontline HIV/HCV/STI workers.** Implement an annual conference to support workers, especially newly hired direct service workers, to keep up to date on the vast landscape of HIV/HCV/STI prevention and care services. Include training on the system of care, referral/linkage protocols, and networking opportunities.		X	X
RE1 EJ1 EJ2	**Community Health Leadership Initiative (CHLI).** Continue to implement CHLI, which provides training on sexual and drug user health and mentorship to people interested in entry-level roles in the field. CHLI also offers internships, funding for micro-grants for community members to launch innovative ideas (e.g., podcasts), workforce appreciation and networking events, and spaces for peer connection.	X	X	X
RE1	**The Academy.** Continue to implement the Academy, with a focus on developing trainings and curricula for supporting the onboarding of new staff, especially those from affected communities (e.g., BIPOC, people with lived experience of HIV/HCV/STIs) working in the HIV/HCV/STI programs and services.	X	X	X
RE1	**Workforce Development Collective.** Convene a multisector Workforce Development Collective that meets monthly, facilitated by the CHLI Program's Workforce Development Director to foster relationship building, organic collaborations, resource sharing, thought partnership, sharing and creating best practices, strategies for burnout prevention and workforce sustainability.	X	X	X
RE1 EJ2	**SFDPH's HIV/HCV/STI counselor training.** Leverage the counselor training to create pathways for meaningful employment by recruiting and supporting people with lived experience of HIV, HCV,	X	X	X

Social Determinant of Health **RACIAL EQUITY**				
Related Strategy(ies)	**Activities**	**2024**	**2025**	**2026 & beyond**
	and STIs to participate in the training and pursue employment in the field.			
RE1 EJ1	**End Hep C SF Leadership Development.** Offer ongoing opportunities for professional and leadership development within the End Hep C SF initiative through supporting community leadership of workgroups, supporting community members to attend conferences and participate in trainings, and providing professional development mentorship to people with lived experience of HCV. *(End Hep C SF)*	X	X	X
RE1 EJ1 EJ2	**SF HIV Frontline Workers Mentor Program (FMP).** Continue to implement the FMP, which provides mentorship to people in entry-level roles who are new to the SF HIV Systems of Care. The FMP builds the capacity of new workers to effectively support their clients, stimulates collaborative cross-agency service delivery, and invests in the professional development of new and veteran workers alike.	X	X	X
RE1	**Leverage current programs to increase workforce racial diversity.** Work with existing workforce development programs, such as the HIV work re-entry program, to ensure that opportunities to support the next generation of HIV/HCV/STI providers better reflect the priority populations in terms of race/ethnicity.	X	X	X
RE2 RE3 RE4	**Racial data stratification to inform resources and programs.** Continue to stratify HIV, HCV, and STI data by race in monthly and annual surveillance reports and present this data to HCPC, Getting to Zero SF, End Hep C SF, and other community stakeholders to inform data-driven resource allocation and program planning.	X	X	X
RE3	**Expand TakeMeHome, a mail order HIV and STI self-testing program.** Expand partnership with TakeMeHome to promote self-testing for ETE priority populations via a variety of placements (websites, social media, through printed materials, via SMS).	X	X	X
RE4	**SFDPH City Clinic Community Perspectives Assessment.** Conduct a Community Perspectives Assessment with SFDPH City Clinic patients and community members to better understand why those who are most vulnerable to HIV infection, including MSM of color, trans women, people experiencing homelessness, and people who use/inject drugs do and do not seek services at City Clinic, to inform how to adapt and market SFCC services to ensure these communities feel well served.	X (conduct assmt.)	X (imple-ment recs.)	X (imple-ment recs.)
RE5	**Participate in available cultural humility and racial justice trainings.** Participate in CDPH's free cultural humility, equity, and racial justice training opportunities (when they become available), the SFDPH HIV Health Services Training Program's racial/culturally specific trainings, and the SFDPH's Black/African American Health Initiative (BAAHI) trainings. Encourage or require community-based providers to participate as training capacity allows.	X	X	X

Introduction

One of the most profound effects of San Francisco's economic shifts has been a surge in the number of San Francisco residents who are unhoused or unstably housed. It is important to note that this is not a monolithic group; it includes people who are temporarily sheltered, people who live outdoors, both individuals and families, and people with and without serious mental health diagnoses. This diversity means that tailored interventions are needed. In particular, the extremely high cost of housing has produced a wave of displacement that has pushed many middle- and working-class individuals and families from San Francisco, especially people of color, to outer areas of the region and has contributed to rapidly accelerating homelessness and housing instability. In San Francisco, people experiencing homelessness represent a large percentage of those diagnosed with HIV and HCV, and PEH are disproportionately represented among cis women with syphilis. Being homeless or marginally housed is strongly and unequivocally linked to poor health outcomes among people living with HIV (PLWH). Homelessness, mental health diagnoses, and substance use disorders frequently co-exist, compounding the challenges in serving this population effectively.

In SF, there are no easy solutions. While SF's HIV/HCV/STI programs cannot solve the housing crisis, SF can **greatly strengthen the connections between HIV/HCV/STI testing and treatment and housing-related services.** As the strategies below demonstrate, we envision this connection working in both directions—expanding HIV, HCV, and STI services in settings that serve people who are homeless or marginally housed while also strengthening access to housing supports such as coordinated entry, housing case management, housing subsidies and service linkages for individuals receiving HIV, HCV, or STI services.

San Francisco Housing First Strategies

(see also *Healthcare Access for All* **and *Mental Health and Substance Use*)**

- ✓ **Strategy 1: Data Collection and Use**
  Improve the ability of local data systems to collect information on housing status so that we can better monitor differences in HIV, HCV, and STI rates and health outcomes by housing status and use this information to inform public health action.

- ✓ **Strategy 2: Strengthening Infrastructure**
  Develop the collaborations necessary for integrated, multidisciplinary, whole-person services in order to effectively address the multiple and complex needs among people experiencing homelessness, including HIV/HCV/STI prevention, screening, and treatment; housing; harm reduction and substance use treatment; and mental health, medical, and social services.

- ✓ **Strategy 3: Street Medicine Strategies**
  Expand and improve coordination of street-based and mobile programs (e.g., walking teams, medical vans, outdoor clinics) that provide medical and support services to people who are unhoused.

Social Determinant of Health

HOUSING FIRST

Related Strategy(ies)	Activities	2024	2025	2026 & beyond
HF1	**Move towards a collective definition of homelessness across local data systems.** Bring into alignment the multiple definitions of homelessness across EPIC (the SFDPH electronic health record), ARIES, HIV prevention data systems, HIV/HCV/STI surveillance, and Department of Homelessness and Supportive Housing (HSH), and other data systems.	X	X	
HF1	**Aim to eliminate disparities in viral load suppression among PEH.** SFDPH Health Services is implementing a CQI project aimed at eliminating the health outcome disparities (viral suppression) in people experiencing housing instability/homelessness for all clients receiving HIV medical care through SFDPH or an HHS funded agency. Data is reviewed on a quarterly basis to inform CQI strategies.	X	X	
HF2	**HIV Homeless Outreach Mobile Engagement (HHOME).** Ensure this program's continued capacity to provide intensive, community-based medical care and case management to PLWH experiencing homelessness who are not comfortable accessing four-walls clinics and to move them along the homelessness-to-housing continuum.	X	X	X
HF2	**Tighten City systems to support smooth access to housing services.** Work with the HIV Housing Workgroup to identify and address weak points in City systems that work together to support housing access, such as partnering with HSH to ensure people with HIV are prioritized during coordinated entry and expanding the impact of Transitional Residential Care Facilities to support housing readiness/independent living skills. *(Mayor's Office of Housing and Community Development)*	X	X	X
HF2 MHSU2	**SF City Clinic staff training on SDoH referrals.** Conduct ongoing training for the LINCS team (DIS and navigators), clinicians, and nurses to strengthen skills in benefits navigation and referrals to housing, mental health, and substance use treatment services.	X	X	X
HF2 MHSU4	**ZSFG pop-up clinic.** Expand the new POP-UP clinic at the Positive Health Program on Ward 86 at Zuckerberg San Francisco General Hospital (ZSFGH). The clinic provides open-access, incentivized, comprehensive, relationship-centered care and enhanced outreach for PLWH not engaged in HIV medical care who are unhoused and not virologically suppressed. Other services include directly-observed therapy and medication pick-ups; behavioral health services, food, clothing, and hygiene kits; and referrals to social services, including vocational training, financial management, legal services, and transportation.	X	X	X
HF2 HAFA2 MHSU4	**Collaborate with HSH to ensure improved access to HIV, HCV, STI, and overdose prevention services.** Work with ~~H~~SH, supportive housing site managers, and tenant leaders to ensure that syringe services, overdose prevention and education, behavioral health, and sexual health services are available at shelters, navigation centers, supportive-housing sites, and single-room occupancy (SRO) hotels.	X	X	X

Social Determinant of Health **HOUSING FIRST**				
Related Strategy(ies)	**Activities**	**2024**	**2025**	**2026 & beyond**
HF2	**Linkage and navigation systems.** For PLWH, people with HCV, and people who are or can become pregnant experiencing homelessness, continue to improve linkage and navigation processes in hospitals, emergency departments, and jails to appropriate HIV primary care, biomedical HIV/STI prevention, and prenatal care destinations.	X	X	X
HF2	**Programs for underrepresented minority (URM) patients.** Support development of novel programs to target needs for URM patients and other special populations. Despite dropping rates of new HIV infections in San Francisco, the incidence of people newly diagnosed with HIV is rising in the Latine community. Getting to Zero SF is working to identify ways to improve the HIV prevention and care cascade for the Latine community. As described above, additional efforts are in place for the HAPs to focus on reaching specific populations (e.g., Black, Latino/a/x/e, PWU/ID, trans women, MSM, youth, etc.) in low-barrier settings. *(Getting to Zero SF)*	X		
HF2	**Advocate for resources for pilot program for PLWH experiencing homelessness.** Advocate for expanding successful evidence-based services like case management for PLWH experiencing homelessness. Identify and apply for funding from external sources to support pilot programs. *(Getting to Zero SF)*	X		
HF2	**Further strengthen housing-related collaborations.** SFDPH already has strong collaborations with the Mayor's Office of Housing and Community Development (MOHCD) and will continue to work with MOHCD to improve efficiencies in HOPWA-supported housing services.	X	X	X
HF2	**Support housing navigation services.** Fund an HIV Housing Navigator to collaborate with HSH and MOHCD to move Coordinated Entry Housing Referral Status clients with HIV through the placement process and ensure that HSH has a way to identify PLWH in the Coordinated Entry system.	X	X	X
HF3	**Improve access to low-barrier programs.** Streamline eligibility criteria for low-barrier and mobile-based HIV programs, and support movement between programs. Create a warm handoff referral guide for programs that focus on low-barrier care and access for PEH, including a small palm card with provider contacts. *(Getting to Zero SF)*	X		
HF3	**Expand availability of long-acting injectable (LAI) ART and PrEP.** Continue to work to expand access to LAI ART and PrEP in and outside of clinic environments, including through Health at Home, partnerships with behavioral health programs, and permanent supportive housing sites with nursing on site, and in collaboration with the Whole Person Integrated Care Initiative (WPIC) in shelters and navigation centers. *Getting to Zero SF* will also support development of pilot studies and research to assess acceptability, feasibility, and efficacy of LAI PrEP and ART, especially for people experiencing homelessness.	X	X	X

Social Determinant of Health **HOUSING FIRST**				
Related Strategy(ies)	**Activities**	**2024**	**2025**	**2026 & beyond**
HF3	**Best practices for mobile care.** Develop and disseminate toolkits for best practices regarding implementation in low-barrier, mobile care models. *(Getting to Zero SF)*	X		
HF3	**Expand SFDPH capacity for mobile HIV/HCV/STI services.** Develop a locally tailored, integrated, harm reduction-based mobile services model ("mobile HAP") for HIV/HCV/STI testing and other prevention services, including overdose prevention and low-threshold access to medication-assisted treatments (MATs) such as naltrexone and buprenorphine. Priority neighborhoods include the Bayview and Mission, where a substantial percentage of the population is Black and Latina/o/e/x, respectively.	X	X	X

Introduction

San Francisco is known throughout the country and the world for its innovative models of HIV, HCV, and STI service delivery, including, but not limited to:

- Integrated, person-centered service models, such as the SFDPH-funded Centers of Excellence and Health Access Points designed for specific populations
- Mobile and street-based health care and support services, provided by Whole Person Integrated Care (WPIC), which includes the Street Medicine Team, and other homeless outreach teams
- Extensive services delivered by peers with lived experience in HIV, HCV, and STI, such as End Hep C SF's HCV Community Health Navigator program
- Comprehensive sexual health services available to all at SF City Clinic

With these successes in mind, SF continues to innovate to break down the barriers to prevention and care access for communities affected by HIV, HCV, and STIs. SF is largely focused on expanding population-specific strategies, as opposed to "one-size-fits-all" models of care. This means making services quick, easy, and readily accessible, as well as redesigning service delivery to be more responsive to the needs of specific populations. Because the population-specific services SF offers are too numerous to name, the activities in this section focus on new and emerging population-specific models of care. In addition, we have highlighted programs that facilitate language access.

San Franciso Health Access for All Strategies

(see also *Housing First* and *Mental Health and Substance Use*)

- ✓ **Strategy 1: Redesigned Care Delivery**
  Work with health care providers, local health departments, public and private insurers, and private industry to increase access to care statewide through mobile healthcare, pharmacy-based care, and at-home testing programs.
- ✓ **Strategy 2: Trauma-Informed and Responsive Services**
  Train medical and public health service providers in trauma-informed approaches to create trauma-responsive care to minimize retraumatization of patients, clients, and providers.
- ✓ **Strategy 3: Fewer Hurdles to Healthcare Coverage**
  Train more community-based organizations to support benefits enrollment in communities with high numbers of uninsured people.
- ✓ **Strategy 4: Culturally and Linguistically Relevant Services**
  Improve capacity of public health and health care providers to offer HIV, HCV, and STI services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- ✓ **Strategy 5: Collaboration and Streamlining**
  Develop secure ways for clinical providers, local health jurisdictions, homeless services programs, and other community-based organizations to share information and resources to coordinate people's care while protecting their right to privacy.

Social Determinant of Health **HEALTH ACCESS FOR ALL**				
Related Strategy(ies)	**Activities**	**2024**	**2025**	**2026 & beyond**
HAFA1	**Implement point of care (POC) syphilis testing for people who are or could become pregnant.** Conduct public health detailing for POC syphilis testing in clinical settings, and issue written guidance for community settings (e.g., HAPs) regarding HIV/HCV/STI testing for this population.	X	X	X
HAFA1 SF4	**Provider education.** City Clinic staff will educate San Francisco Health Network providers to improve knowledge and comfort around sexual health care, including guidance and technical assistance on identifying risk factors and conducting appropriate screening and treatment for syphilis, as well as pregnancy and STI counseling.	X	X	X
HAFA1 HAFA5	**Syphilis screening workflows.** Develop workflows in the emergency department and urgent care that facilitate syphilis screening before discharge for all pregnant people, PEH, people with a history of meth use, and those receiving a HIV test.	X (develop)	X (imple-ment)	X (imple-ment)
HAFA1 HAFA5 SF4	**Increase HIV, HCV, and STI screening, and PrEP prescribing at ZSFG.** Through clinical education, consultation, and continuous QI efforts, clinical champions will work to implement the following improved protocols: 1) asking all hospitalized patients about HIV transmission risk factors to see if they qualify for PrEP counseling; 2) ordering HIV/HCV/STI testing; and 3) initiating or referring to PrEP if indicated.	X	X	X
HAFA4	**Advertising of sexual health services.** City Clinic will create and disseminate public services video ads, in multiple languages, on social media and social networking sites aimed at increasing access to City Clinic testing, treatment, and vaccination services for HIV, STI, HCV, and Mpox.	X	X	X
HAFA1	**Accelerate efforts to increase PrEP use.** We will implement a multi-layered strategy to address barriers to PrEP uptake, including regionally with Alameda County, with a focus on improving PrEP provision to people of color, trans women, PWUD, and people who are unhoused. Strategies will include expanding PrEP 2-1-1; mobile PrEP; making PrEP available at Mission Wellness pharmacy; and same-day PrEP models.	X	X	X
HAFA1	**Self-collection/home testing.** SF is partnering with the TakeMeHome program to provide free mail order kits with the following: HIV dried blood spot test and STI self-test kits (oral, vaginal, and anal swabs, and urine for CT/GC and dried blood spot for syphilis). Users of networking apps, like Grindr, can access ordering links embedded within HIV-related app content and they will also be able to access their lab-based results through a secure portal. SFDPH will promote this program on websites and social media, through printed materials, and via mobile texts.	X	X	X
HAFA1 HAFA2	**Improve low-threshold, trauma-informed, substance use harm reduction services in community settings.** Integrate HIV/HCV/STI	X	X	X

Social Determinant of Health **HEALTH ACCESS FOR ALL**				
Related Strategy(ies)	**Activities**	**2024**	**2025**	**2026 & beyond**
MHSU2 MHSU4	prevention and care services, contingency management services to address methamphetamine use, and street-based/mobile behavioral health and harm reduction education, referrals and linkages.			
HAFA3	**Increase training and access to information on benefits enrollment.** Train providers on current issues related to benefits enrollment, including complexities of navigating the AIDS Drug Assistance Program (ADAP), Office of AIDS-Health Insurance Premium Payment (HIPP) Assistance (OA-HIPP), Employer-Based HIPP (EB-HIPP), and Medicare Part D Premium Payment Assistance (MPPP). Develop client-facing materials to educate clients on these and other benefits options.	X	X	X
HAFA4	**Continue to improve language access to comprehensive services.** SFDPH funds several programs where services can be accessed in Spanish and A&PI languages. Spanish services include outpatient mental health for PLWH. The following services are available through the COEs and HAPs in both Spanish and A&PI languages: HIV/HCV/STI testing, linkage and navigation, harm reduction and syringe access services, HIV/HCV/STI health education and prevention, services to meet basic needs (such as food security), HIV primary care, HIV PrEP, ART, HCV treatment, STI treatment, mental health services, and a host of wraparound services. SFDPH will continue to assess demand for services in other languages (such as Portuguese) and implement improvements as needed.	X	X	X
HAFA5	**Expand care coordination (CC).** Continue to build on current CC efforts, such as weekly, cross-agency, multi-disciplinary care coordination calls (with follow-up via EPIC charting, chat, emails, and calls), including calls focused on pregnant people experiencing homelessness and HIV not-in-care.	X	X	X
HAFA5	**Make data systems that support making CC more accessible to community-based organizations and medical providers.** In 2021, City Clinic transitioned to the SFDPH-wide enterprise electronic health record, EPIC, which has improved STI/HIV care coordination across SFDPH providers. SFDPH will continue to identify areas where data access would improve care, such as ensuring that all HIV/HCV/STI community-based providers have access to the One System—the Coordinated Entry System for housing services—as well as other key systems.	X	X	
HAFA5	**Develop a sustainable inventory of services, including eligibility criteria, location and hours, and referral procedures.** Explore possible solutions to fragmented and duplicative resource lists and client referral procedures, such as collaborating with https://sfserviceguide.org/ to expand its resource inventory, leveraging the Frontline Organizing Group's listserv to provide	X	X	X

Social Determinant of Health **HEALTH ACCESS FOR ALL**				
Related Strategy(ies)	**Activities**	**2024**	**2025**	**2026 & beyond**
	regular updates to changes in services, and/or issuing a monthly newsletter to HIV/HCV/STI CBOs.			
HAFA5	**Streamline linkages for people released from jail.** Expand HIV/HCV/STI treatment, care, and prevention navigation services to three HAP sites to establish a comprehensive, streamlined service model for people who are newly released from SF County Jail.		X	X

Introduction

The trifecta of homelessness, mental health, and substance use is one of the key drivers of new HIV, HCV, and STI infections, and has contributed to an alarming uptick of fatal overdoses in SF in recent years. In San Francisco, access to culturally appropriate mental health and substance use services is an essential component of HIV, HCV, and STI prevention and care. But that access is still limited for many of the people who most need it, despite Medi-Cal expansion, Mental Health SF and other attempts to increase access.

SF's success at addressing mental health and substance use will rely on the following overarching approaches:

- Improving and expanding options for harm reduction and substance use treatment, including low-barrier medication assisted treatment (MAT) and comprehensive syringe services programs, regardless of HIV, HCV, or STI status;
- Ensuring equitable access to naloxone and overdose prevention and response trainings; and
- Partnering with SFDPH Behavioral Health Services (BHS) and the San Francisco Behavioral Access Center (BHAC) to work towards expanding availability of systemwide access to mental health services.

SAN FRANCISO MENTAL HEALTH AND SUBSTANCE USE STRATEGIES

(see also **Housing First** and **Healthcare Access for All**)

✓ **Strategy 1: Overdose prevention in correctional settings**
Promote medication for opioid use disorder during incarceration in prison and jails and naloxone distribution and continuity of substance use disorder and medical care upon release.

✓ **Strategy 2: Mental health and substance use disorder treatment access through telehealth**
Leverage telehealth to increase access to mental health and SUD services, especially for people newly linked to stable housing and people who are monolingual in a language other than English.

✓ **Strategy 3: Build harm reduction infrastructure**
Expand syringe services in federally qualified health centers, hospitals, and SUD treatment facilities; build up staffing, brick and mortar locations, and comprehensive support services (health, legal, housing, benefits, employment) in existing syringe services programs.

✓ **Strategy 4: Expand low-threshold SUD treatment options**
Expand options for harm reduction-based treatment, including contingency management programs and easier access to buprenorphine and methadone, including in street medicine programs.

✓ **Strategy 5: Cross-Sector Collaboration**
Encourage collaboration between local and statewide mental health programs, substance use programs, and harm reduction and HIV/HCV/STI programs.

Social Determinant of Health **MENTAL HEALTH AND SUBSTANCE USE**				
Related Strategy(ies)	**Activities**	**2024**	**2025**	**2026 & beyond**
MHSU1	**Comprehensive status-neutral sexual and drug user health services in jails, including naloxone.** SFDPH's Jail Health Services provides HIV, HCV, and STI testing, naloxone, HIV primary care, and a wide range of other services to people experiencing incarceration. A goal for 2024-2026 is to move towards status-neutral services, where HIV care is not siloed from prevention so that all can benefit from the whole suite of services, including overdose prevention and HCV and STI services.	X	X	X
MHSU1	**Comprehensive support for PLWH upon discharge from jail.** Support comprehensive medical care and support services to people exiting SF jails, including case management, referral, and linkage to vital medical, behavioral health, and support services to people exiting jail. A navigator coordinates care and plans post-release services, meeting clients directly upon their release from jail (especially for those released at night, when regular services and support systems are unavailable) or as soon as possible. The navigator stays engaged with clients for at least 90 days following release.	X	X	X
MHSU3 MHSU4	**Continue to provide comprehensive community-based drug user health services.** The Health Access Point for people who use drugs provides comprehensive sexual and drug user health services, as do many other programs. In addition to the full suite of sexual health services, the following are also available: medication storage, safer injection and drug use supplies, harm reduction support, naloxone, drug sample testing, and substance use treatment.	X	X	X
MHSU5	**Implement the most feasible recommendations from the HIV Mental Health Landscape Analysis.** These recommendations will improve service access, delivery, and cross-referral for PLWH.	X	X	X
MHSU5	**Collaborate with SAMHSA-funded programs.** Increase collaboration and coordination with and among SAMHSA-funded programs in place at local CBOs.	X	X	X

Introduction

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

The sustainability of SF's rich network of high-quality HIV, HCV, and STI services relies on being able to hire and retain a highly qualified, diverse workforce. Anecdotally, sexual and drug user health nonprofits are having unprecedented challenges in filling positions, given the high cost of living in SF and the surrounding Bay Area. The San Francisco Living Wage Coalition estimates that in 2023, the minimum livable wage would be $29.92/hour for a single adult with no children; yet, SF's legal minimum wage is $18.07, with a modest increase to $18.67 slated to go into place 7/1/2024.

At the same time, as of April 2024, SF City and County is facing a several billion dollar budget deficit, necessitating funding cuts across all city departments. In addition, in 2024, SFDPH received funding cuts from formula-based CDC awards due to a decline in the number of PLWH in SF. These economic realities make it even more challenging to successfully implement economic justice strategies such as wage equity initiatives.

SAN FRANCISO ECONOMIC JUSTICE STRATEGIES

(see also *Racial Equity*)

- ✓ **Strategy 1: Workforce Development**
  Create pathways to employment in public health for people from communities most affected by HIV, HCV, and STIs, including, but not limited to, offering paid internships and entry-level positions with clear opportunities for professional advancement.
- ✓ **Strategy 2: Employment for People with Lived Experience**
  Encourage programs that employ people with lived experience in the communities the program serves, programs that can demonstrate frontline staff are paid a living wage, and/or programs that have BIPOC people serving in meaningful leadership positions.
- ✓ **Strategy 3: Equitable Hiring Practices and Fair Pay**
  Examine state and local health jurisdiction hiring practices to promote equity and inclusion; look to remove barriers such as college and advanced degree requirements; offer extra pay to people who speak languages other than English or who have lived experience with HIV, HCV, STIs, substance use, mental health challenges, or homelessness.
- ✓ **Strategy 4: Leadership Development**
  Fund and support pilot training programs for development of leadership and management skills among frontline and mid-level workers in HIV, HCV, and STI programs.
- ✓ **Strategy 5: Universal Hiring and Housing Policies**
  Work with community partners and other State agencies to move toward universal "ban the box" hiring and housing policies in California, which remove questions about criminal history from the job application process until after a candidate has been given a chance to show whether they qualify for the position.

Social Determinant of Health **ECONOMIC JUSTICE**				
Related Strategy(ies)	**Activities**	**2024**	**2025**	**2026 & beyond**
EJ1 EJ2	**Develop employment pathways for people with lived experience.** Through CHLI, FOG, and other workforce initiatives, create pathways for people with lived experience to receive training, earn certificates, and be linked to potential job opportunities, with a special focus on PLWH who are looking to re-enter the workforce	X	X	X
EJ3 EJ5 RE1	**Promote "Strengthening the HIV/HCV/STI Workforce."** This workforce equity resource guide for employers in the HIV, HCV, and STI sectors offers resources, examples, and best practices for recruitment, hiring, and retention of BIPOC and people with lived experience. There is a strong emphasis on wage equity, as well as information about hiring formerly incarcerated people. *(Workforce Development Collective)*	X	X	X
EJ3	**Encourage CBO wage equity initiatives.** Some community-based organizations are conducting compensation studies that lead to organizational changes toward wage equity.	X	X	X
EJ3	**Explore innovative approaches to removing barriers to employment and retention.** For both SFDPH and its funded CBOs, look for opportunities to remove barriers, such as not requiring advanced degrees for positions that do not need them, incorporating retention pay into benefits packages, or offering premium pay to workers who speak any of the non-English languages commonly spoken in SF.	X	X	X

Introduction

During the community engagement process that informed SF's 2020 Ending the Epidemics Plan, a recurring theme among participants was their experience of stigma. Stigma was a topic in every community engagement session, and in some cases was cited by participants as the largest barrier to accessing healthcare. Participants experience stigma from both providers and other community members related to HIV, race, gender, sexuality, immigration status, drug use, and homelessness. These stigmatizing actions take different forms: trans women described having to articulate that they are not "men who have sex with men" when being questioned around HIV risk; people experiencing homelessness feel unwelcome in healthcare facilities due to lack of access to spaces where they can clean themselves; PWUD describe having their complaints of pain ignored by providers. Particularly within communities of color, anti-gay stigma was felt to be a barrier to testing or treatment.

Participants named several approaches to help combat stigma in health care systems, and these are reflected in SF's strategies and activities:

- Provider education on delivering culturally appropriate sexual and drug user health services;
- Acknowledgment of and taking responsibility for past harms, and working toward ending current mistreatment; and
- Normalization of HIV/HCV/STI testing, as part of a larger health screening package that also includes screening for other conditions such as diabetes.

SAN FRANCISO STIGMA FREE STRATEGIES

- ✓ **Strategy 1: Nothing About Us Without Us**
  Meaningfully and consistently involve people living with HIV, HCV, and STIs in state and local planning, decision making, and service delivery.
- ✓ **Strategy 2: Reframe Policies and Messaging**
  Work with communities to reframe the structure and policies of HIV, HCV, and STI services and associated messaging so they do not stigmatize people or behaviors.
- ✓ **Strategy 3: Positive, Accurate Information**
  Ensure images and language used in communications show accurate and diverse depictions of communities, and do not reinforce stereotypes; speak out against and correct negative language.
- ✓ **Strategy 4: Acknowledge Medical Mistrust**
  Recognize medical mistrust as a rational response to stigmatizing treatment, rather than a failure of individuals or communities; work to build trust and correct misperceptions by example.
- ✓ **Strategy 5: Ongoing Partnerships**
  Use 'promotores' and other models of paid peer engagement by people from the communities being served to educate, support, advocate for, and link to care people who have historically been mistreated by public health services and the health care system.

Social Determinant of Health **STIGMA FREE**				
Related Strategy(ies)	**Activities**	**2024**	**2025**	**2026**
SF1	**SF Ending the Epidemics community engagement.** Continue innovative community engagement activities to obtain community guidance on all SF Ending the Epidemics activities by issuing community mini-grants to engage with key subpopulations.	X	X	X
SF1	**Participation of people with lived experience in HCV planning.** Define and publicize different roles that individuals can play in End Hep C SF, taking into account barriers related to experience, confidence, time of day, physical accessibility, technological know-how, and available time to participate. *(End Hep C SF)*	X	X	X
SF1	**End Hep C Community meetings.** Relaunch End Hep C SF community meetings, which before COVID-19 were a vital opportunity twice a year to break bread, learn together, and have fun meeting new people who are also committed to eliminating HCV. *(End Hep C SF)*	X	X	X
SF1	**Partnership with SF HIV Community Planning Council (HCPC).** Strengthen the partnership with HCPC and engage them in ending the epidemics discussions. Provide annual updates to the HCPC regarding cluster response. Include a representative from the SFCC leadership team on the HCPC and present an SF City Clinic update to the HCPC at least once per year and obtain input on gaps in HIV/STI services and prioritization, both at SFCC and citywide.	X	X	X
SF1 SF3	**Develop an approach to community engagement with youth.** Work with youth organizations to engage youth in conversations about sexual and drug user health and include them in policy and program development.	X	X	X
SF1 SF2 SF3	**Develop and implement a prevention social marketing campaign for the Latina/o/e/x community.** Bring together the Latina/o/e/x HAP agencies and other key partners to develop a media campaign to increase awareness and uptake of prevention services, especially HIV/HCV/STI testing and PrEP. The campaign will be inclusive of monolingual Spanish speakers, including new immigrants from Latin America.	X (develop)	X (imple-ment)	X (imple-ment)
SF2	**STI Community Conversations.** Host a series of "Community Conversations" to better understand the community's perspective on sexual health and sexual health services in SF and at SFCC, and to determine how to adapt SFCC services to ensure these communities are well-served. We plan to collaborate with CBOs (e.g., the CAPs, CBO HAP providers) to recruit community members from priority populations to participate in the conversations.	X		
SF3 HAFA4	**Update City Clinic website to improve inclusivity.** Update website images and language to reflect diversity of SF, including in threshold languages: English, Spanish, Russian, Vietnamese, Tagalog, and Chinese.	X		
SF4	**Public health detailing.** Conduct public health detailing to routinize HIV/HCV/STI risk assessment and screening and PrEP and doxy-PEP	X		

Social Determinant of Health **STIGMA FREE**				
Related Strategy(ies)	**Activities**	**2024**	**2025**	**2026**
	assessment and referral in medical settings so that provider bias does not factor into who is offered these services.			
SF5	**Peer programs.** Continue to encourage and support SFDPH-funded HIV/HCV/STI community-based organizations to incorporate peer programs.	X	X	X

For more information, visit:

https://sf.gov/departments/department-public-health

Please direct questions and comments to:

dph-chepadmin@sfdph.org

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Department of Public Health

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