SFAF Evaluation Indicators

FY18-19 and FY19-20

Introduction

In July of 2019, San Francisco AIDS Foundation (SFAF) released a 5-year strategic plan that promised to reshape the way that SFAF prioritizes health justice and centers priority communities previously underserved, including people of color, people experiencing homelessness and unstable housing, people over age 50, people living with hepatitis C, people who use substances, and people with mental health care needs.

Once the strategic plan was released, SFAF then worked with an external consulting firm (Facente Consulting) to develop a rigorous plan to regularly evaluate progress toward eliminating health disparities and better meeting the needs of people in these communities, particularly to meet seven 5-year targets, which we ambitiously strive to reach by end of 2024, when this strategic plan will be replaced with a new plan for our next chapter. These targets are:

1. **People living with HIV will have equal rates of viral suppression regardless of race and ethnicity**
2. **Fewer than 100 people living in San Francisco will newly acquire HIV in 2024.**
3. **90% fewer people living with HIV will have hepatitis C because of increased awareness, testing, and treatment.**
4. **50% fewer long-term survivors will experience isolation, poor physical health, or unmet mental health needs.**
5. **10,000 overdoses will be prevented or reversed over 5 years because of prevention efforts, including safe injection services.**
6. **Disparities in sexual health and substance use outcomes among SFAF clients by ethnicity, gender, housing status, and injection behavior will be reduced to 5 percentage points or less.**
7. **90% of SFAF clients using substances will be able to access treatment and other harm reduction support to manage their use and maintain wellness.**

This report highlights our first year of progress toward achieving these targets, measuring both quantitative progress toward a series of indicators under each target, and qualitative feedback from staff about how well we are meeting the goals of the strategic plan we've laid out.

Methods

To develop this evaluation plan, SFAF's Senior Director for Program Strategy and Evaluation, Jen Hecht, worked closely with Shelley Facente, Principal at Facente Consulting, to review existing data within the organization and determine the best indicators for measuring progress.

The first step was to look through the detailed strategic plan, identifying any strategies highlighted in the plan in service of each of the plan's goals and 5-year targets and determining what data

points (if any) could be used to determine whether these goals were being met. This list was formulated into a formal list of indicators, which were then categorized both by 5-year target (see Appendix 1) and by existing SFAF data source (see Appendix 2). Once indicators had been finalized, Evaluation Analyst Dharma Bhatta worked with Data Analyst Jason Bena and Data Administrator Namrata Mohanty to gather and analyze data from the various datasets to track and plot outcomes for each indicator by quarter. This system can now be used to regularly track additional datapoints as they become available each quarter, for each indicator, allowing SFAF to continuously assess our progress.

Additional work was done to analyze the implications of observed trends, and to understand the underlying issues that may be impacting progress (positively or negatively – including COVID-19, which resulted in shelter-in-place orders dramatically impacting SFAF services in Q4 of FY19-20).

Finally, the team determined a number of areas where "deeper dives" were warranted, to better understand the true impacts of changes being made to improve services at SFAF. Those topics were addressed through qualitative interviews, and the methods and findings of that qualitative work is detailed toward the end of this report.

Progress on Indicators

In FY20, SFAF served over 25,000 clients across all services and programs.
The following sections, organized by each of the five-year targets, provide insight into our progress.

People living with HIV will have equal rate of viral suppression regardless of race and ethnicity.

Viral suppression is achieved through ongoing access to HIV care. For our purposes, we looked at the following indicators:

- clients who received a new HIV diagnosis at one of our testing sites
- clients who accessed “rapid” ART, or immediate start of ART upon diagnosis of HIV
- clients who accessed interim ART (iART), or interim HIV care because they were out of care or struggling to get their medications due to transitions in their health care, with the ultimate goal of identifying a primary care home for them

The total number of new HIV diagnoses totaled 48 in FY19 and 39 in FY20. Of these clients, 85.4% (41 out of 48) accessed Rapid ART services at SFAF in FY19 and 87.2% (34 out of 39) in FY20.

In total, SFAF provided “Rapid” ART to 15% more clients in FY19-20 compared to FY18-19 (when comparing quarters 1-3). As word has gotten out, clients and external providers have referred newly-diagnosed individuals to SFAF. For this reason, the number of clients who accessed Rapid ART exceeded new diagnoses.

Not surprisingly, most Rapid ART initiations occur at Magnet at Strut. We are working to expand this service to 1035 Market as well as the Harm Reduction Center, with support from a California Office of AIDS demonstration project grant. Shelter-in-place has slowed our efforts at 1035 Market, which has been closed, and limited the use of indoor space at the Harm Reduction Center.

Figure 1: Number of Rapid ART Starts and New HIV Diagnoses at SFAF

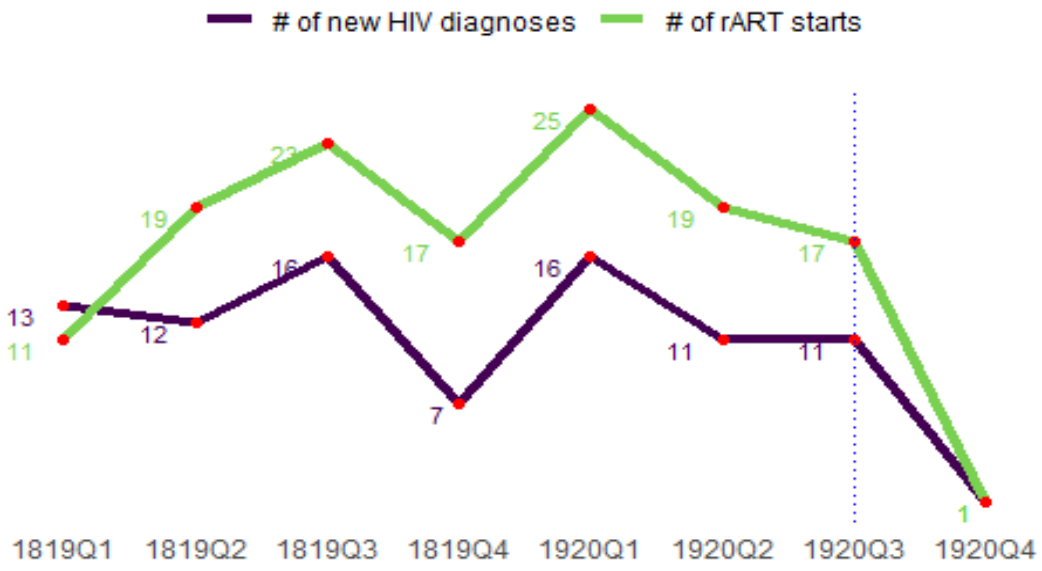


Figure 2: Number of HIV rapid ART starts by site

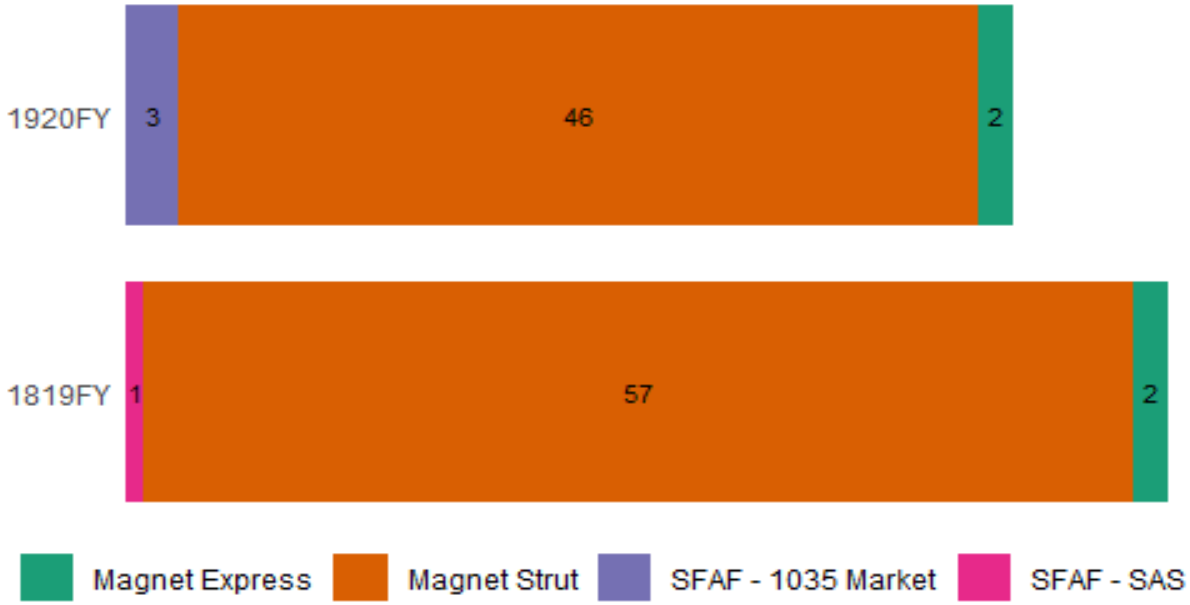
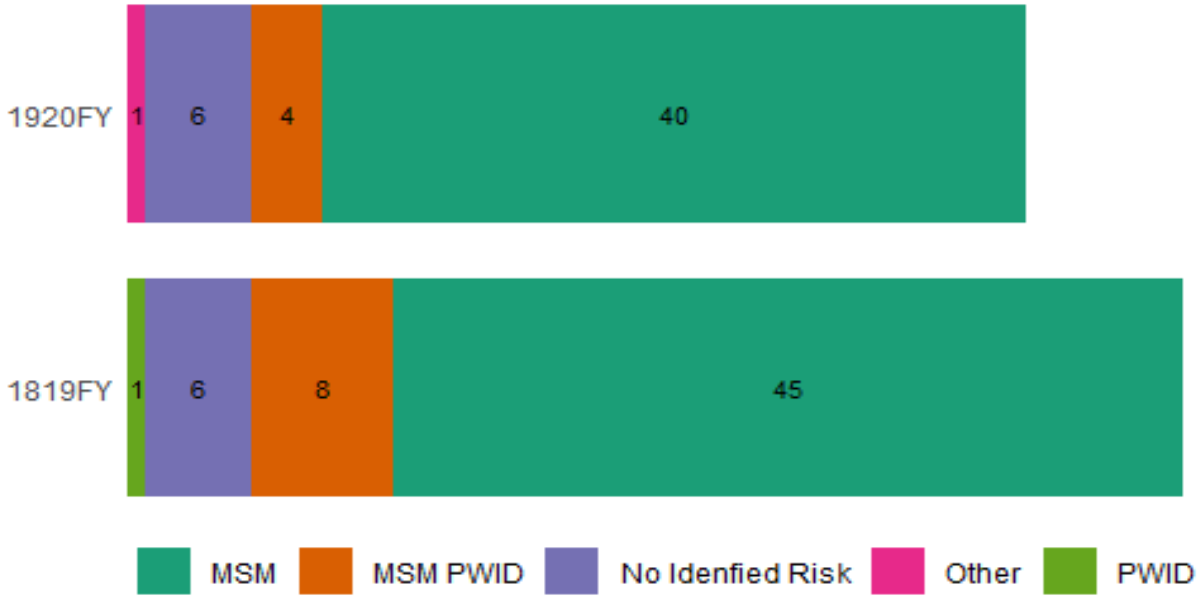
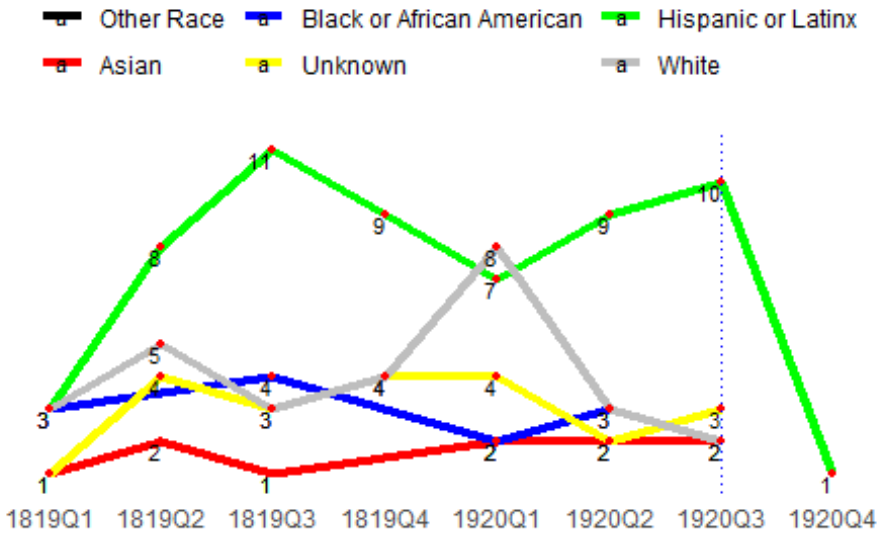


Figure 3: Number of HIV rapid ART starts by BRP



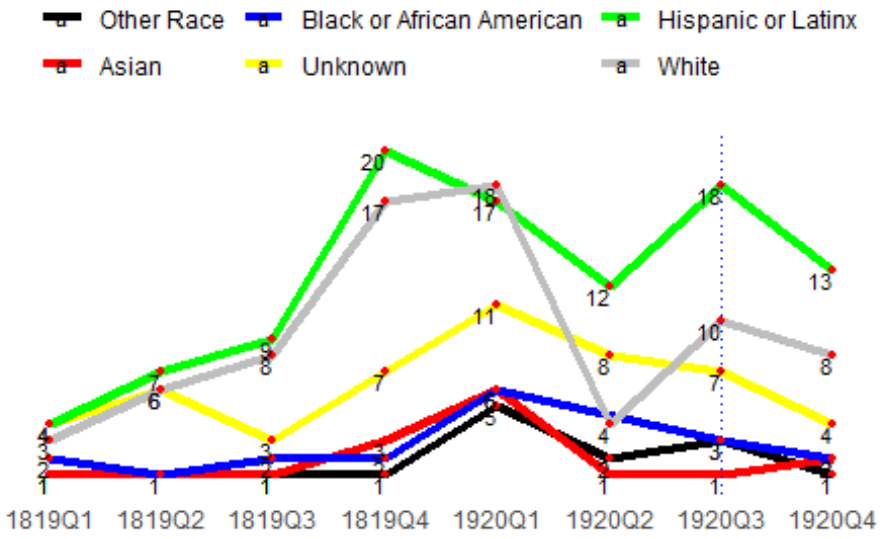
Compared to citywide data on new diagnoses, SFAF is serving a larger proportion of MSM and a smaller proportion of people who inject drugs for HIV medical services. "No identified risk" indicates that we do not have data on the risk profile of this client; most likely they declined to answer the risk questions. "Other" is defined as having a partner who injects drugs, an HIV+ partner, being a transwoman with transmission risk (sex with men, PWID, partner PWID).

Figure 4: Number of HIV rapid ART starts by race/ethnicity



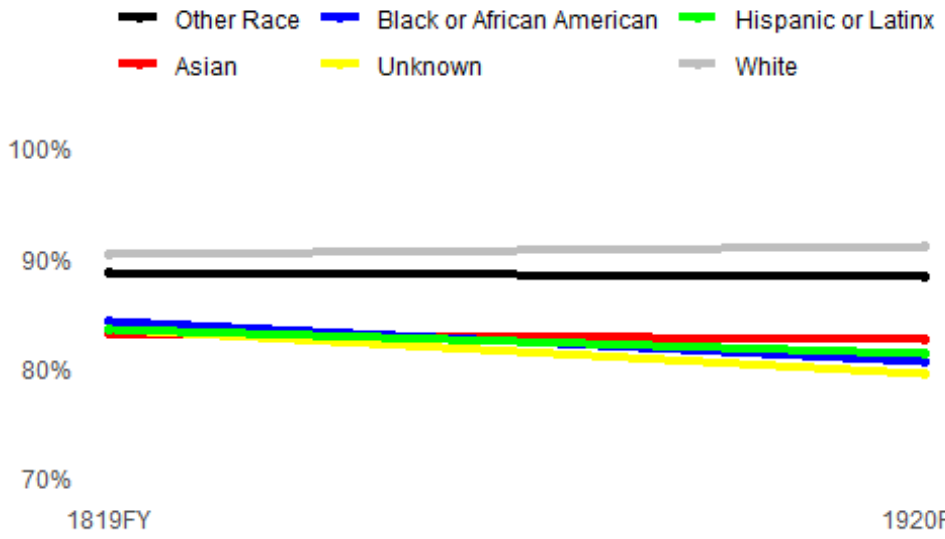
Latinx individuals make up the largest number and percentage among SFAF's new diagnoses (44%) and Rapid clients (58%). This aligns with and exceeds citywide data (38%). 67% of clients accessing Rapid ART in FY20 were BIPOC.

Figure 5: Number of iARTs by race/ethnicity



iARTs are interim HIV medications prescribed by nurse practitioners to clients who are out of care or in transition in their health care. Similar to Rapid ART rates at SFAF, Latinx clients have been accessing this service at a significant volume.

Figure 6: % virally suppressed by race/ethnicity

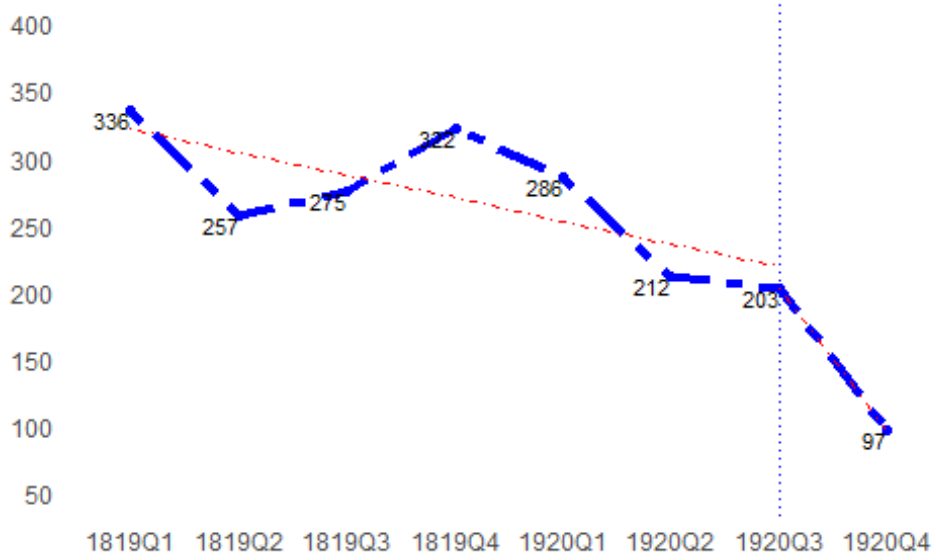


As a part of client registration and satisfaction surveys, SFAF clients self-report whether or not they are virally suppressed. Viral suppression represents control of HIV in the body and an ability to stop onward transmission. White clients have disproportionately high rates of viral suppression, compared to other ethnicities. San Francisco data overall shows an average of 74% of HIV+ individuals with a suppressed viral load.

Fewer than 100 people living in San Francisco will newly acquire HIV in 2024.

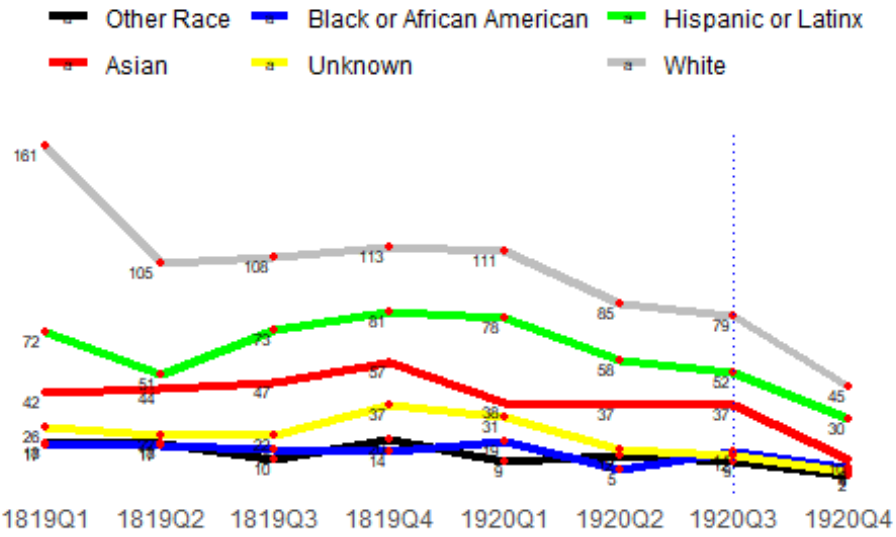
Prevention of new HIV diagnoses is achieved through many factors, including access to biomedical interventions, such as PrEP and PEP, as well as viral suppression achieved through ongoing HIV care.

Figure 7: Number of PrEP enrollments



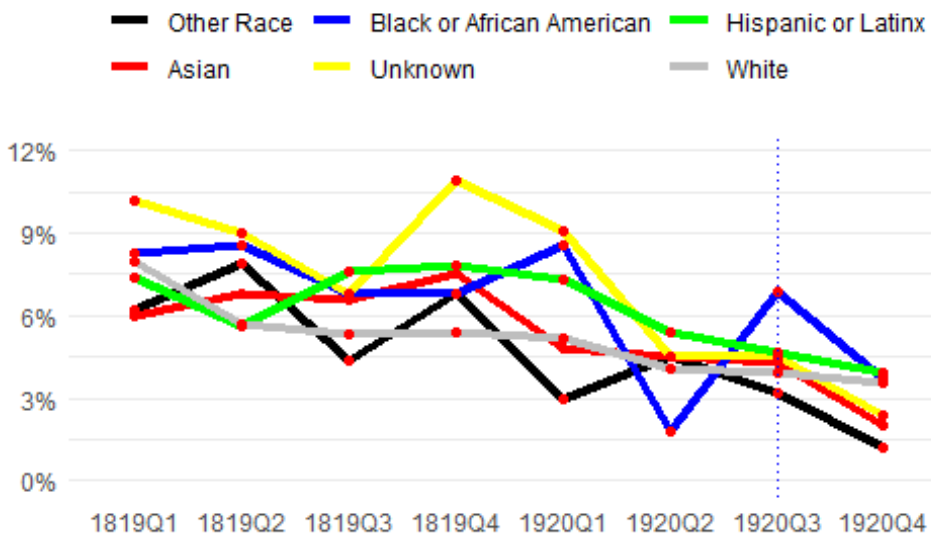
In FY20, SFAF enrolled 804 clients into the PrEP program. Before COVID-19, Magnet was seeing a decline in new PrEP enrollments, largely due to an increasing number of current PrEP program clients, as well as expanding numbers of iART and Rapid clients (which are very time-consuming appointments). There is an ongoing review to ensure a proper balance across visit types. Demand for PrEP at Magnet continues to be high.

Figure 8: Number of PrEP enrollments by race/ethnicity



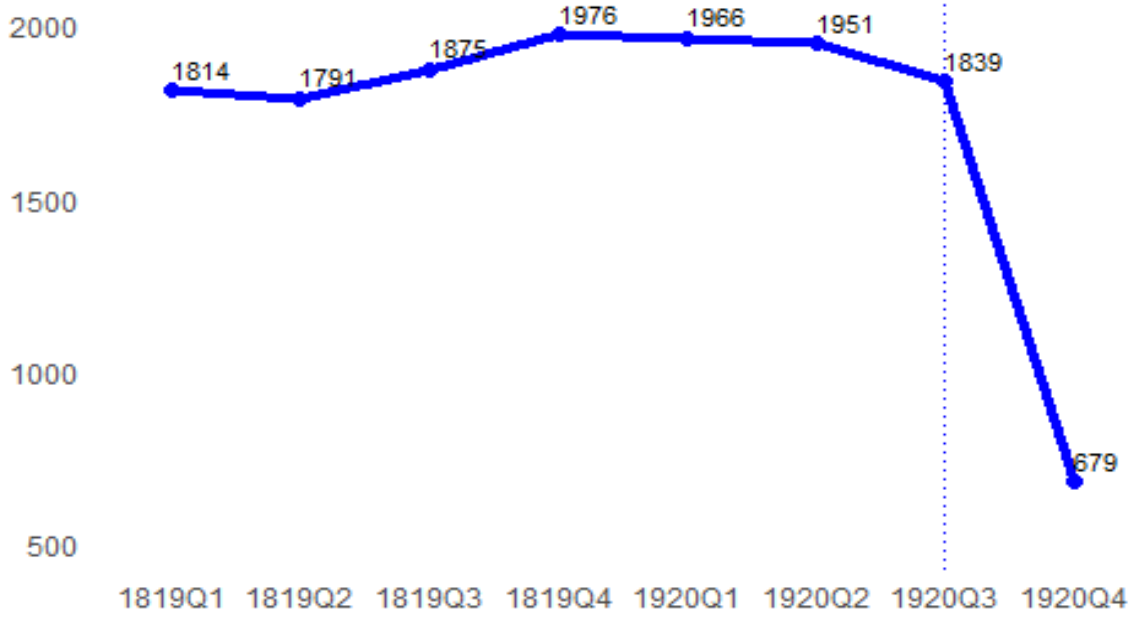
Of those who were enrolled in SFAF's PrEP program in FY20, 61% were BIPOC. Between FY19 and FY20, enrollments among white clients decreased the most significantly. We have seen a slight decrease in the disparity in PrEP enrollments between white and BIPOC clients at SFAF. Efforts like QTBIPOC at Strut, in which the clinic sets aside appointments for BIPOC clients during events for this community, have been a part of this success.

Figure 9: % of PrEP enrollments by race/ethnicity per quarter



Amongst PrEP enrollments, we see a decline over the past 2 years across all races/ethnicities. We have seen an improvement in data completeness on race/ethnicity data.

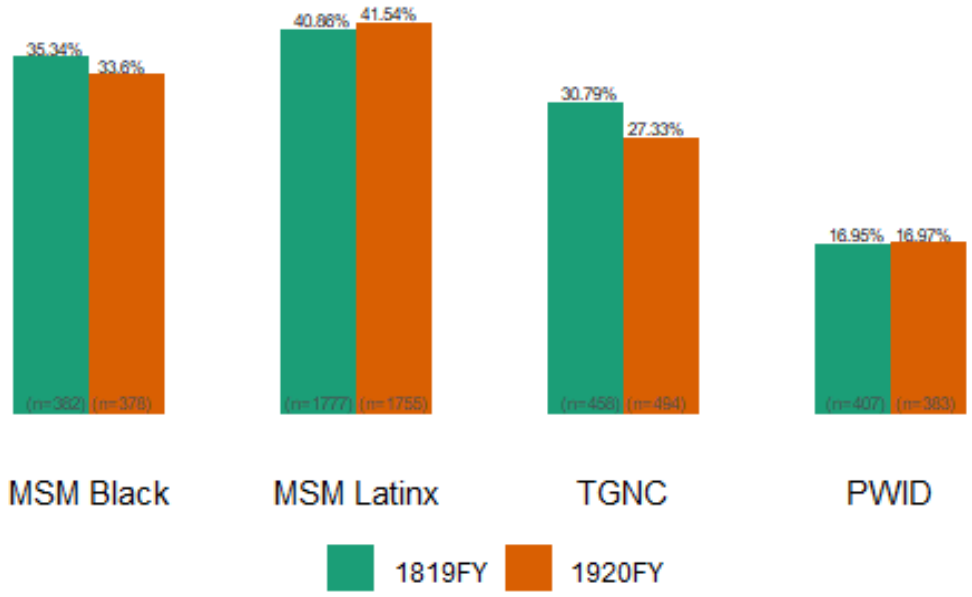
Figure 10: Number of all PrEP Program participants



SFAF has seen a steady increase in the number of active PrEP program participants since the launch of PrEP at SFAF (until shelter-in-place). During FY18-19, the PrEP program engaged 3227 total

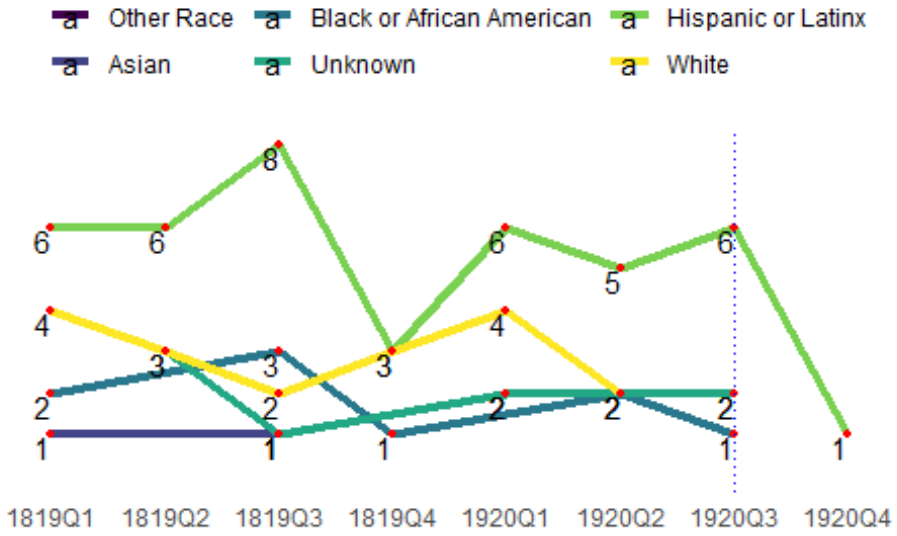
clients. In FY19-20, the program engaged 3141 total clients, a decrease of 3%. (Note: currently, "active" PrEP clients are determined by an appointment within the past 7 months, which has been greatly impacted by SIP, however, we will be able to add prescription data soon to improve this metric.)

Figure 11: % of Black MSM, Hispanic or Latinx MSM, TGNC, and PWID who report being on PrEP



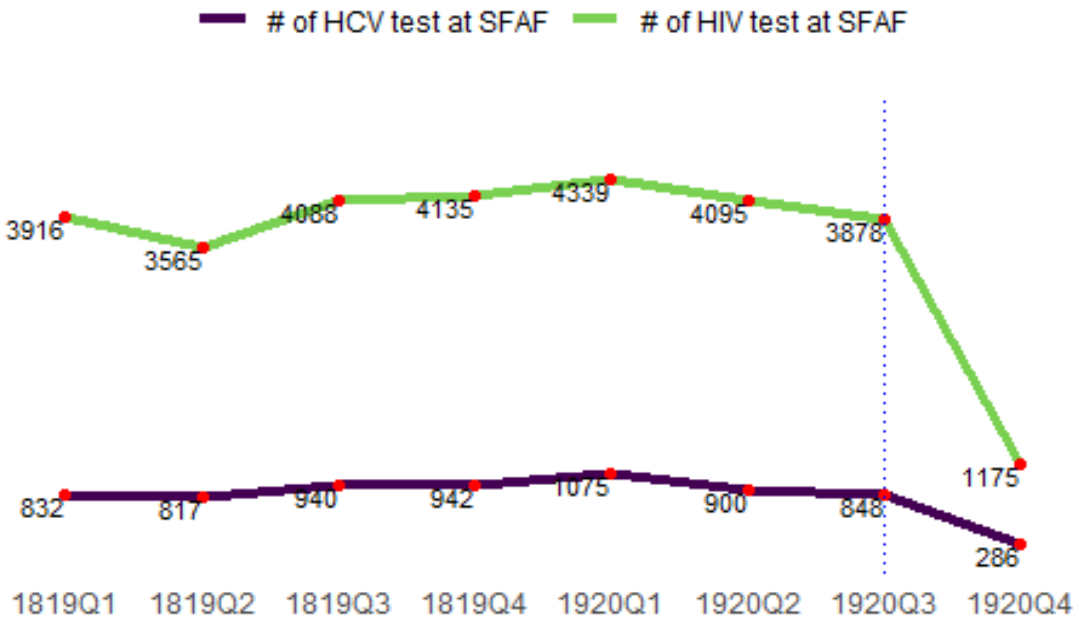
We've seen a slight decrease in proportion of Black and TGNC individuals on PrEP from baseline to Year 1, but a substantial increase in volume. This compares to 37% in FY 18-19 and 41% in FY19-20 for white MSM. In FY20, approximately 56% of PrEP program participants were BIPOC.

Figure 12: Number of new HIV diagnoses at SFAF by race/ethnicity



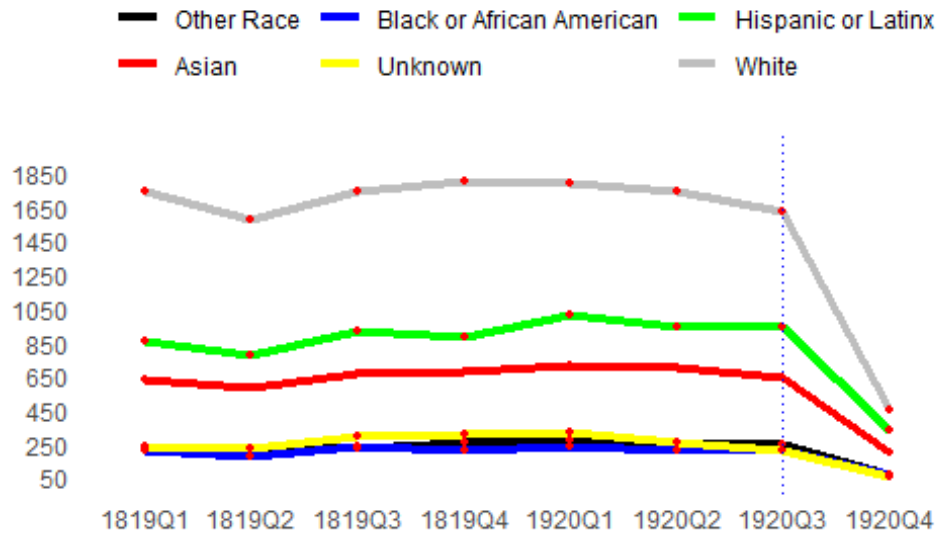
In FY18-19, SFAF testing efforts identified 46 new HIV diagnoses. In FY19-20, the number of HIV diagnoses totaled 39. A large proportion of SFAF new diagnoses have consistently been among Latinx clients.

Figure 13: Number of HCV and HIV tests at SFAF



SFAF conducted 18,124 HIV tests in FY18-19 and 15,317 HIV tests in FY19-20. SFAF has increased HIV testing most quarters (and was on trajectory to do so for Q3 19-20 as well until SIP). Increases over the past 2 years have generally been about 15% per year. SFAF conducted 3628 HCV tests in FY18-19 and 3222 HCV tests in FY19-20. HCV test volume is driven by PrEP enrollments (43.9% of HCV tests in FY19 and 34.3% in FY20). Among people who inject drugs (10% of HCV tests), HCV testing was on target to exceed FY19 totals before SIP occurred.

Figure 14: Number of HIV tests at SFAF by race/ethnicity



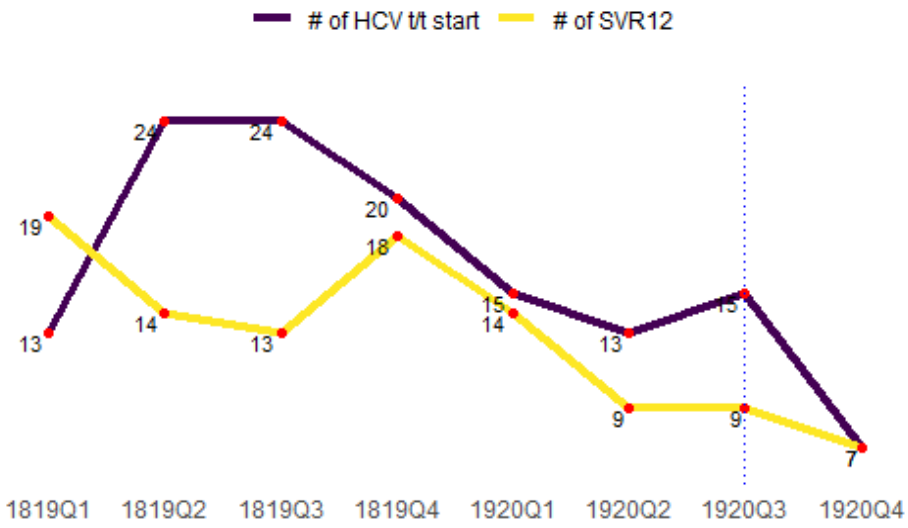
While the largest volume of tests remains among white clients, we've seen a 10-15% increase in testing among Latinx clients at SFAF and a 10% increase among Asian & Pacific Islander clients since FY19. Of note, our mobile testing, Harm Reduction Center, and Mid-Market locations all see a higher proportion of BIPOC clients than our Magnet site.

90% fewer people living with HIV will have hepatitis C because of increased awareness, testing, and treatment.

Figure 15: Number of HCV treatment starts, number of people who achieve HCV SVR12

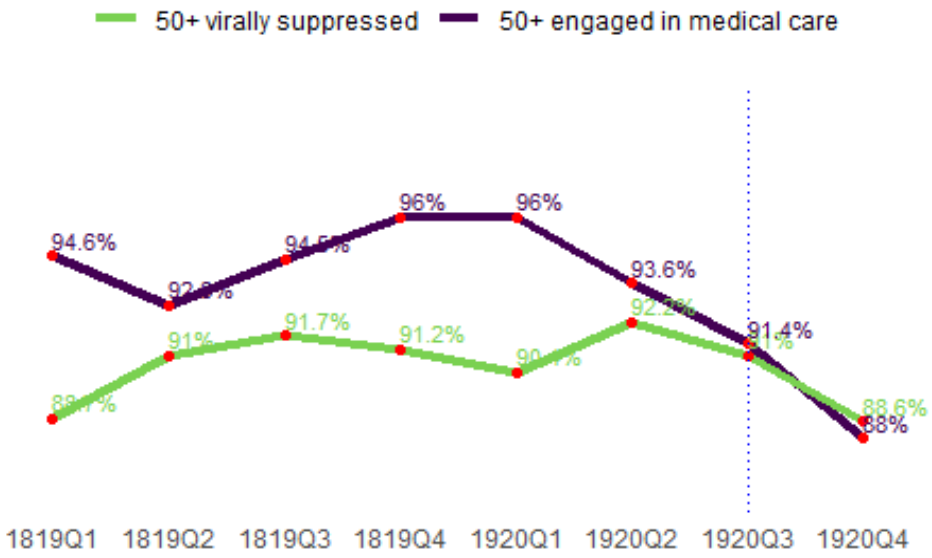
SFAF prioritizes providing HCV treatment onsite for individuals who might not otherwise be able to access treatment, particularly people who inject drugs and/or are experiencing homelessness. A very high proportion of individuals who begin HCV treatment are able to complete it. In FY19, 83 people initiated HCV treatment and 51 achieved SVR12. The largest numbers of HCV treatment initiations occurred between Q2 and Q3 of FY19. In FY20, this decreased, in part due to staffing transitions; 54 initiated treatment and 39 achieved SVR12.

In FY19 10 clients and FY20, 6 clients living with HIV initiated HCV treatment. Currently, most individuals living with HIV who are linked to care engage in HCV treatment with their existing provider. We have just begun standardizing questions about HCV testing and treatment across all program areas. Expanding conversations with clients living with HIV about HCV testing and treatment will be an area of focus in Year 2 and beyond of the strategic plan.



50% fewer long- term survivors will experience isolation, poor physical health, or unmet mental health needs.

Figure 16: % of SFAF clients age 50+ engaged in medical care and who are virally suppressed among HIV positive



A very high proportion of SFAF clients across all programs over age 50 are virally suppressed; while this has fluctuated a bit, it exceeds citywide targets for viral suppression. This data is collected by client self-report.

10,000 overdoses will be prevented or reversed over 5 years because of prevention efforts, including safe injection services.

Overdose is prevented or reversed through training and distribution of Narcan/Naloxone as well as access to support and harm reduction supplies at the Harm Reduction Center and through our mobile sites. Each year, syringe access services (SAS) engages approximately 18,000 unduplicated clients annually.

In FY19, SFAF trained 4400 people to administer naloxone. This number increased in FY20; however, Q3 and Q4 data is still being gathered. In FY19, clients reported 1003 overdose reversals. Overdose reversal totals are still being gathered for FY20 but trends indicate an increase in comparison to the previous year. During calendar year, approximately 26,000 doses of NARCAN were distributed. We are working to update our data collection on NARCAN, as we've been depending on an external partner for this data.

Figure 17: Naloxone trainings and OD Reversals

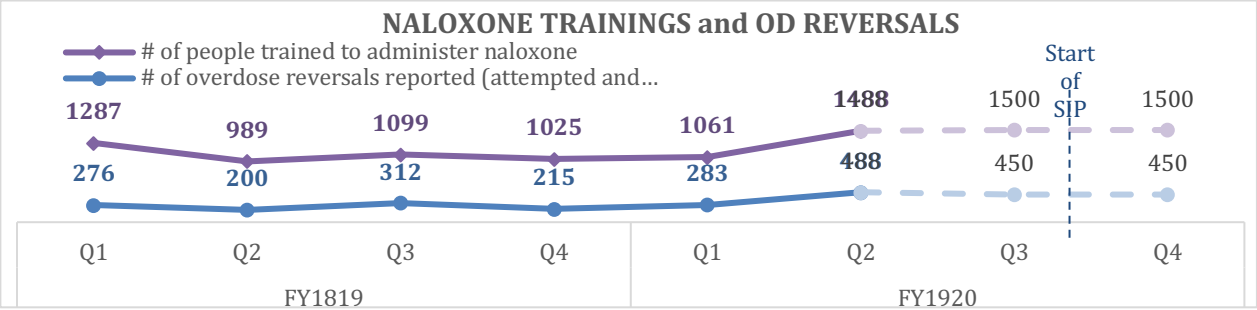
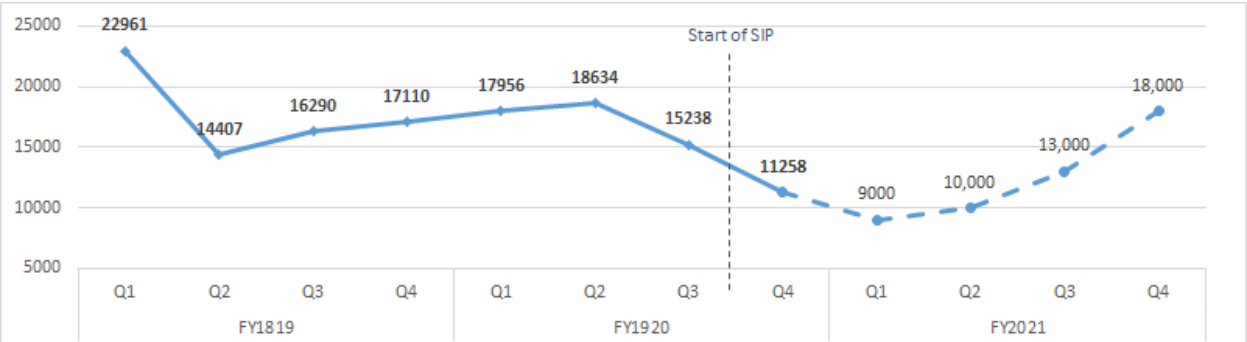


Figure 18: Number of SAS contacts per quarter



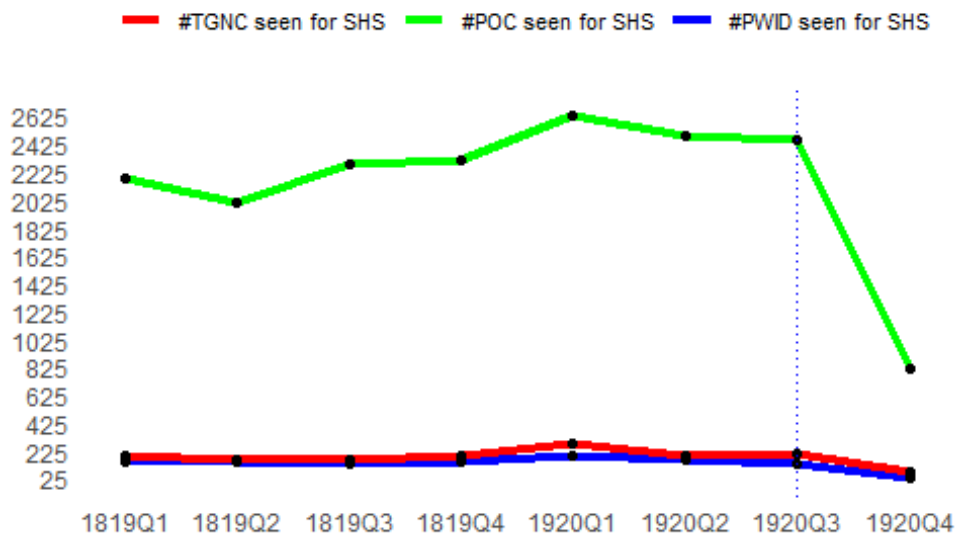
SFAF engaged 70,768 duplicated clients in FY19. These numbers were increasing in FY20 until SIP (total for FY20 was 63,086). Contacts include engagement at the Harm Reduction Center and across all mobile sites.

Disparities in sexual health and substance use outcomes among SFAF clients by ethnicity, gender, housing status, and injection behavior will be reduced to 5 percentage points or less.

Disparities in outcomes are measured by evaluating the number of clients from our priority communities (e.g. trans and nonbinary, people who inject drugs, and BIPOC clients) who access sexual health and substance use services.

SFAF increased client engagement among priority communities from 18-19 Q1-Q3 to 19-20 Q1-Q3: a 12% increase in BIPOC and 23% increase in TGNC clients served by sexual health services. Sexual health services include HIV, HCV, and STI testing and treatment; PrEP and PEP; benefits navigation; and trans healthcare.

Figure 19: Number of TGNC, PWID and BIPOC seen for sexual health services



90% of SFAF clients using substances will be able to access treatment and other harm reduction support to manage their use and maintain wellness.

In FY19 and FY20, SFAF distributed 3,618,015 and 3,453,113 syringes respectively. These numbers dropped during Shelter-In-Place and may have already begun to decrease due to shifts in drug patterns – primarily, increases in fentanyl use (which require increases in other types of harm reduction supplies).

Figure 20: Syringes Distributed by Quarter

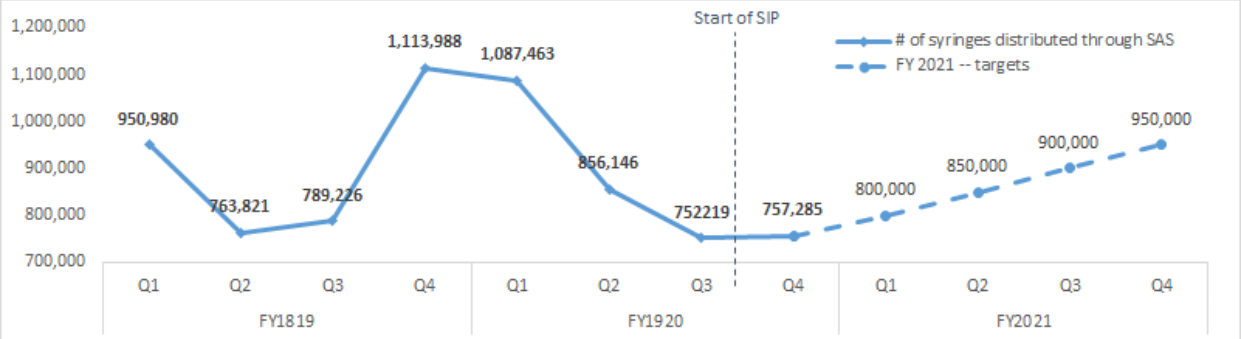
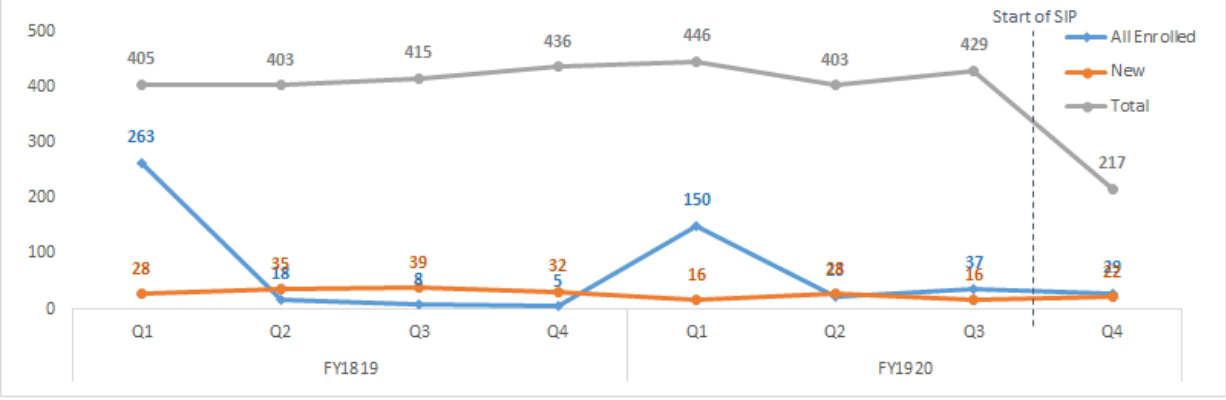


Figure 21: Unduplicated clients at Stonewall



Note: "All Enrolled" clients were de-duplicated each quarter across the year, so that the number of clients in each successive quarter were added to those who started at the beginning of the year (many of whom rolled over from the prior year). For "Total" and "New" clients, the numbers represent unduplicated clients each quarter. Total clients served in Stonewall for FY20 was 812. Stonewall implemented a new electronic health record during this year, limiting access to data through the full year (this will improve dramatically for FY21).

Qualitative Findings: Taking a "Deep Dive"

Summary of Methods

In year one, SFAF developed an evaluation plan to monitor the progress of the new strategic plan. The evaluation plan includes both a quantitative and qualitative component. This section summarizes the qualitative component: staff feedback collected through individual interviews. The goal of the interviews was to gain an in-depth understanding of staff's perspective on the progress made during Year 1 of the new strategic plan, especially in areas not easily measured through quantitative indicators.

From late May to early June 2019, Facente Consulting conducted nine one-hour individual interviews with SFAF staff. The staff represented a diverse sample of the Foundation's workforce, including different:

- genders,
- programs,
- departments,
- years of employment,
- front-line versus leadership positions, and
- primary site (e.g., 1035, Magnet, Stonewall).

A semi-structured interview guide was created to facilitate the discussion. All interviews were conducted via Zoom and audio/video recorded for notes purposes only.

The findings from the interviews are grouped into eleven key themes. The themes are further organized into three elements of SFAF's Strategic Plan: strategic priorities, priority communities, and core strategies.

Strategic Priorities

Theme 1: Staff were satisfied with the progress their department made in implementing their strategic priorities, but they were unsure of the progress on the priorities in which they were not actively involved.

Staff clearly identified the organization's new emphasis on racial justice and prioritizing communities most impacted by disparities, but some felt SFAF was not living its principles (subsequent themes will elaborate on this). Staff were quick to note changes their department made in response to SFAF's new strategic plan. However, staff could not easily identify changes to the strategic priorities that were outside their purview, particularly changes to Strategic Priority #3 (i.e., create a network for PLWH over the age of 50). Siloes might be a contributing factor, but staff also believe SFAF should explicitly call out changes being made across the agency in response to the strategic plan, to help people in other programs better tie in those changes in their own work.

The table below highlights the strategic planning changes staff identified as having already occurred:

Priority #1: Expand and maintain HIV, hepatitis C, and STI prevention and treatment, and other sexual health services to ensure equitable access and utilization by people of color.	• Amplify HCV services at SAS • Strengthen HIV linkage to care • Expand STI testing to mobile services • Outreach to BIPOC neighborhoods • Translation of materials
Priority #2: Expand and maintain existing substance use services, syringe access, and overdose prevention efforts, including establishing safer injection sites.	• Hire staff dedicated to BIPOC at Stonewall • Plan a substance use program for trans women • Integrate substance use services at Castro • Provide Narcan training to staff
Priority #3: In partnership, create a comprehensive network of health and wellness services for all people over the age of 50 who are living with HIV.	• Hire staff to support the program
Priority #4: Strengthen organizational excellence with a focus on living our values, including a commitment to racial justice.	• Establish DEI committee • Establish racial justice workgroup • Hire more BIPOC and bilingual staff • Create BIPOC-specific events

Strategic Priority #4

Key Initiative #1: Foster an organizational culture of diversity, equity, and inclusion.

Theme 2: Staff generally feel safe and respected in the organization, but the work culture and staff interactions can be improved.

Most staff shared that SFAF is a place where they feel respect from all levels in the organization. Managers are approachable and willing to have conversations around improvements or concerns. Staff recognize the concerted efforts SFAF leadership is doing to create a safe and welcoming workplace for all. However, staff expressed that certain staff in leadership positions do not take change well, especially when it has been the norm for the organization, or it challenges what they built. Also, the work culture in SFAF can be enhanced. Aside from experiencing gossip in the workplace, some staff experience a competitive and detached culture that isolate staff from one another. Instead of lifting each other up, some peers ignore others even though they share the same office space or belittle their efforts.

Theme 3: SFAF has made concrete changes to center staff of color and these efforts need to continually evolve and expand.

The biggest effort staff noticed is an increase in hiring people from SFAF's priority populations. Front-line staff are now more representative of the populations the organization prioritizes to serve; SFAF has more people of color, bilingual staff, and trans and gender non-conforming (TGNC) staff. There are more women in leadership, and leadership positions have been created to improve the organization's work culture. In addition to intensifying these efforts, staff noted two areas where SFAF can expand its impact:

- Hire more Black/African American and Asian & Pacific Islander staff – there is little representation of those two groups

- Ensure newly hired individuals have resources to succeed and flourish in their new roles – see Theme 4

Key Initiative #2: Improve employee engagement through increased commitment to and investment in talent.

Theme 4: SFAF can improve the integration of staff into the workplace, especially those that are from the priority populations.

SFAF has made conscious efforts to hire staff from the organization's priority populations – BIPOC, TGNC, bilingual folks, people with lived experiences of substance use or being unhoused, etc. – but staff shared they need professional development and an inclusive workplace to succeed in their positions. Staff recommended the following:

> *"The more that you put into a staff member, into their own development, the more they will look for ways to stay in the organization and thrive within the org."*

- Provide Spanish-language accessibility in staff meetings and written documents/materials for Spanish-speaking staff
- Make the onboarding process more robust by setting expectations, clearly defining roles and responsibilities, and highlighting the programs and services offered at SFAF
- Support staff professional development through mentorship and frequent check-ins with managers and supervisors
- Improve inclusivity by dismantling transphobia in the workplace, promoting better pronoun usage, and creating more mandatory (not voluntary) diversity, inclusion, and equity efforts

Key Initiative #3: Establish and maintain an integrated and effective organizational structure and identity.

Theme 5: SFAF has unified somewhat under the new strategic plan but siloes still exist within the organization.

> *"Instead of a beehive, SFAF is a field of separate ant hills. Each is autonomous, working well. There is not a way we are working together."*

Under the new strategic plan, SFAF has started to come together to create a unified body with a common goal. However, staff described SFAF as still being siloed, perpetuating miscommunication among departments, lack of coordination between departments, and a disjointed internal client referral system. Yet, staff appreciate the autonomy programs receive because it respects each program's individuality, clientele, and purpose. Staff believe there is an opportunity for each department to have its own mission and values while still being part of a cohesive, larger body. A more unified organization would enable staff to provide responsive programming, but also provide clients with all the resources SFAF offers.

Theme 6: Staff know the direction SFAF is taking with the new strategic plan, but they are not as well-informed about what is happening within departments outside their own.

Staff understand and value SFAF's new strategic priorities and focus on the priority populations. All-staff meetings, presentations from the CEO, and communication from leadership have made SFAF's new direction clear to everyone. Staff are also kept abreast of important updates relevant to their departments, yet, many staff shared they are unaware of the operations and happenings of different programs and how everything fits together. Communication of updates exists, but staff often feel overwhelmed by the sheer number of updates via Teams, emails, newsletters, etc. There are so many programs and events happening across multiple sites that staff often find it difficult to not only keep track of activities across the agency, but also to see how they all tie together.

> *"We're such a big organization. There's always a lot happening, so it's challenging staying up to date."*

During the shelter-in-place order, many staff felt more much informed about the organization than before the order. Staff now have a better understanding of SFAF and the operations of different programs. This is the result of more meetings with managers, being able to see cross-department calendars, and the circulation of condensed organization-wide emails (e.g., Ben's program update). Staff are more informed of current resources and events now, which they can now share with clients to improve their care and experience at SFAF.

Theme 7: Staff appreciated the opportunities to participate in strategic planning changes, but SFAF's new strategic plan has not been completely embodied by the organization.

Supervisors and managers actively support staff involvement in strategic planning changes at both the organization- and department-level. When asked, managers provided staff with time to create new plans for their programs. Staff have also been able to attend meetings and workgroups that support BIPOC and racial justice efforts across their organization. Because of these new opportunities, staff feel supported in transforming their work, which showcases SFAF's investment in their staff. However, staff shared a few concerns they would like to see improved:

- Follow-up from meetings – staff share their ideas with leadership at meetings that solicit staff feedback, but many are unsure what happens afterward with their feedback
- Provide support to enact changes – managers are expected to implement changes and complete deliverables without additional staff support

Lastly, staff shared that not everyone in the organization is proactively committed to act on SFAF's new racial justice and equity vision. Specifically, staff of color are often left with the burden of creating change for clients of color and leading racial justice efforts within the organization. All staff, not just staff of color, need to be involved in these new strategic efforts and support the creation of programs and services for clients of color.

> *"Staff of color are left to carry the weight of racial justice, instead of everyone… It seems like it's a priority for staff of color to support communities of color, instead of everyone prioritizing to provide that support across."*

Priority communities

Theme 8: SFAF has created meaningful changes to center people of color, but the agency can improve engagement with and provision of services to communities most impacted by health and racial disparities.

SFAF has created more programming for people of color, and the organization is actively working to make everyone feel welcome at their spaces. Magnet and Stonewall have historically been seen as serving gay, white, cis men, but SFAF is changing that perception and creating spaces where BIPOC and TGNC folks feel comfortable to attend. This has in part been achieved by hiring staff that reflect clients, offering bilingual materials, and creating marketing materials that showcase the diversity among clients. Staff shared next steps to continue the organization's efforts:

- Remove barriers to access e.g., the sign-in pad at 1035 Market is currently only available in English, not in Spanish
- Expedite translation of materials and information – new communication material is often created for clients, but translation is delayed and seems like an afterthought
- Focus on the social and economic factors of health – SFAF cannot improve clients' health without addressing employment, education, housing, etc.

> *"There are structural and access barriers [within SFAF] that make it challenging for certain communities to access help."*

Staff identified communities SFAF is struggling to serve well. Below is a list of the groups of people and recommendations to improve SFAF's engagement with the communities.

Asian & Pacific Islander (A/PI) community	• Hire more A/PI staff • Build trust with the Chinese community to improve drug testing efforts. SFAF is barely testing this community but stigma and lack of trust are barriers.
Black/African American (B/AA) community	• Hire more B/AA staff • Adopt new models of care – the current models (e.g., counseling, case management) do not work as well for B/AA men, and are very Eurocentric
BIPOC	• Continue making sites more inclusive – e.g., BIPOC and TGNC folks have historically not felt welcome in the Castro; Strut is very gay White men-facing • Create services where BIPOC live/socialize – e.g., create a space (and/or partner with CBOs) in the Mission to hold services for Latinx MSM
People experiencing homelessness	• Provide services and groups to shelters or other community centers
Spanish-speakers	• Hire more bilingual Spanish-speakers • Offer more Spanish language services – e.g., there is high need for services among Spanish-speakers who use substances

Trans & Non-Binary	• Create more trans programming • Dismantle transphobia in the organization – e.g., address microaggressions, cultural sensitivity trainings • Continue making sites more inclusive – see BIPOC above
Women	• Improve outreach and marketing – women may assume SFAF services are for gay men only • Build capacity to see women in clinical sites and improved protocols for these examinations

Theme 9: SFAF should prioritize services to communities with few and limited services and adopt new strategies to better engage and retain these communities.
Most staff agreed that SFAF should prioritize services to communities with fewer resources and limited access to resources. These communities are most at-risk and have been disproportionally impacted by social and racial inequities. Given that there are limited resources, SFAF should prioritize these communities while still welcoming long-standing clients. Staff proposed the following strategies to better serve and center communities with few and limited resources:

- Improve outreach efforts. Go directly to the communities, maintain a presence, and provide direct services where the live/socialize – do not expect them to come to a SFAF site.
- Support a BIPOC pipeline program. Offer scholarships and training opportunities for BIPOC to work directly with priority populations, particularly in the behavioral health field.
- Hire more case managers. SFAF lacks case managers to help all clients navigate the social safety net, particularly among BIPOC and PLWH.
- Create or join partnerships that prioritize our communities. Join or work with collaboratives whose goal is to improve the overall health and well-being of SFAF's priority populations.
- Improve access to services. Offer extended hours for services and programs (i.e., beyond 8am-5pm) and make services available at all sites (e.g., clients can only access computer services at 1035 Market, not Strut).

> *"The Foundation needs to become embedded in those communities. Certain people are not coming to Downtown or to the Castro. In order for us to reach our goal, we need to come to them and have a presence in those communities."*

Core Strategies

Advocacy

Theme 10: Some staff are unaware of SFAF's current advocacy efforts, but collaborations between program and policy are an untapped tool staff want to explore.
Few staff were familiar with SFAF's policy arm and the advocacy efforts they lead or support. Staff want to learn about SFAF's policy efforts so they can better envision how programs and policy can support each other. For the staff who were aware of SFAF's policy efforts, they appreciated SFAF taking a forward-facing position on Prop C and

organizing grassroot support to ensure the ballot passed. Similar efforts should be continued. Staff shared the following ways programs and policy can collaborate:

- Detail the effects of new governmental policies on SFAF and clients. For example, under the CARES Act clients may lose protected confidentiality on their SUD records
- Policy staff shadow programs and have conversations with staff to learn which policies SFAF should be actively advocating
- Solicit staff feedback to inform current advocacy efforts
- Join or create partnerships – see Theme 11

Strengthen and build community partnerships

Theme 11: Internal and external partnerships are necessary to achieve SFAF's vision.

Staff identified internal and external partnerships that would build on the strategic priorities and expand SFAF's impact in the community. The table below summarizes staff recommendations.

INTERNAL OPPORTUNITIES

Create standard policies and workflows	Particularly for clinical services, convene staff and leadership from different sites to ensure workflows and polices are being uniformly implemented
QTPOC and other groups of color events	Similar to QTPOC's repeating Thursday night events, other groups of color should have nights set aside for them to socialize and receive medical care
Substance use and PrEP services	Substance use counselors and the PrEP program should work together to provide their services to clients
Stonewall and Magnet	Clinical and mental health services should be more integrated. Mental health and substance use support is needed

EXTERNAL OPPORTUNITIES

Join or create collaboratives	Leverage the power of cross-sector collaboratives to create policy changes and to address the social and economic barriers clients experience. For example: • Harm reduction collaborative for the Spanish-speaking community • Trans-focused collaborative of different providers and stakeholders • Partnerships with the East Bay to address housing, HIV, HCV • Substance use provider network to protect privacy of clients
Learn best-practices from the experts and other agencies	Work with agencies that are experts in their topic or help a population SFAF wants to serve better. In return, the Foundation should offer their expertise in sexual health and substance use services. For example, work with • Openhouse for the PLWH 50-Plus group • Thrive SS for trans programming • CBOs in the Bayview area to reach B/AA folks • DPH clinics to learn about their medical model of care

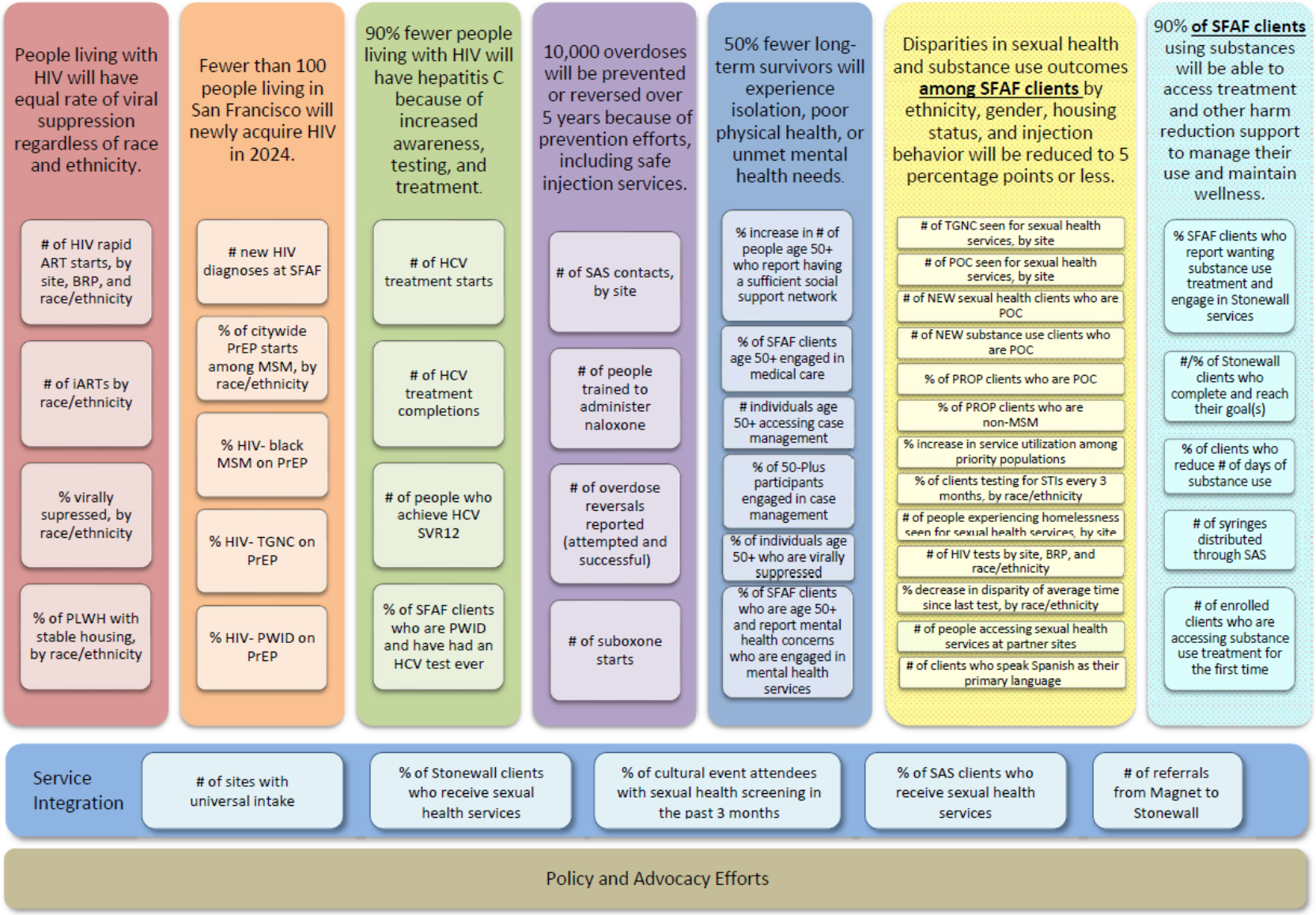
Create a cultural competency training	Create a training for external providers that would increase cultural competency on providing sexual health and substance use services in a non-judgmental and non-traumatic manner

Conclusions

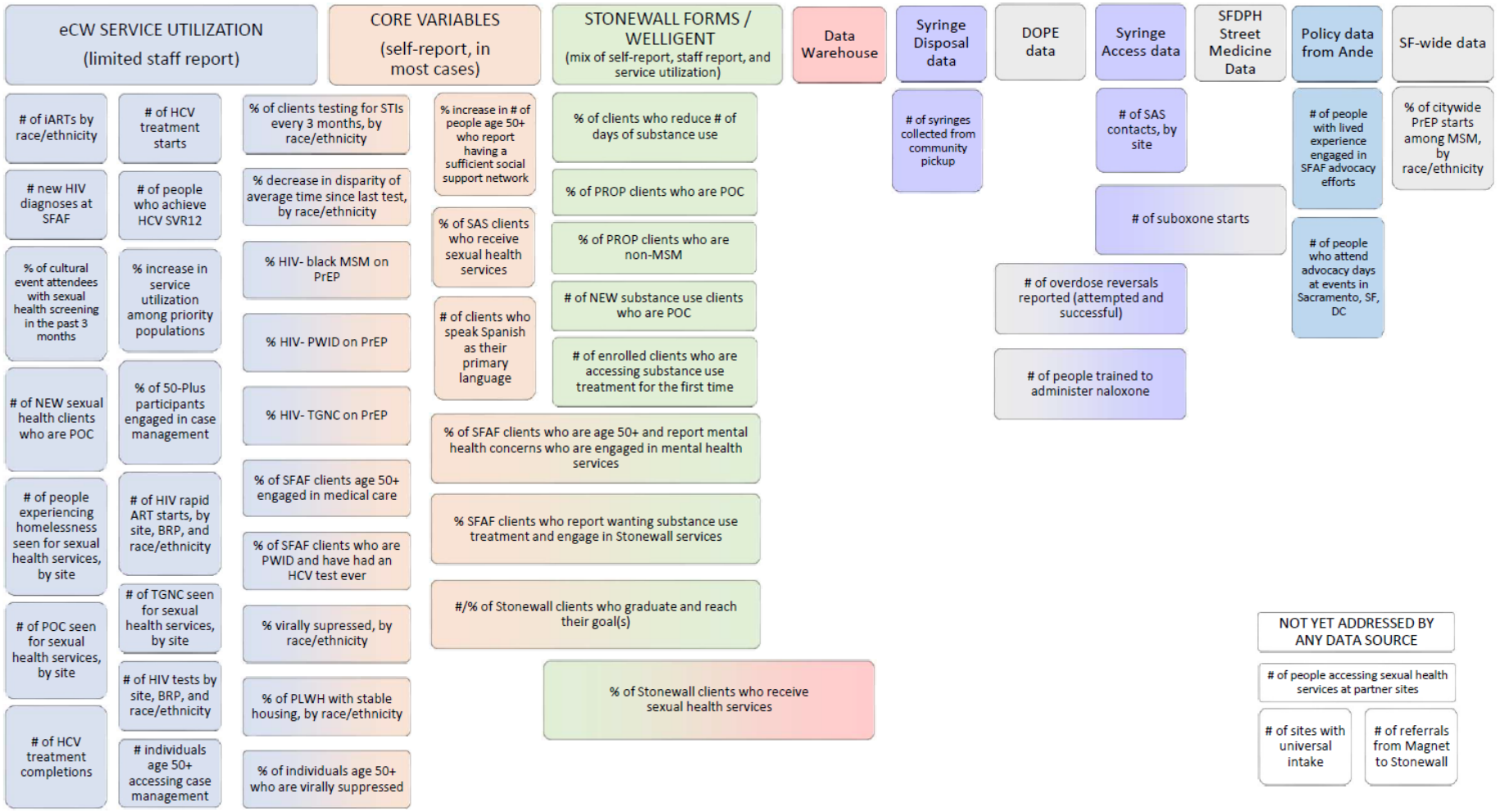
Overall, much of this last year was spent identifying indicators, developing the evaluation plan, and designing systems for regular analysis and reporting of progress on indicators and in qualitative areas. It was also spent reacting to COVID-19, personally and professionally, in ways that profoundly impacted the services SFAF clients received.

Despite all this, it is obvious that some progress has been made – or had been made before shelter-in-place restrictions prevented us from keeping our momentum. As our society moves into a long-term "new normal" under COVID-19, it will be more important than ever to look at our data closely to determine how our progress has been impacted, and what we can do to return trends to the trajectory we once had – or better yet, to increase our rate of progress even more.

Appendix 1 – Evaluation Indicators by 5-year Target, 2019-2024



Appendix 2 – Evaluation Indicators by Data Source



Appendix 3 – Data Tables

[*Note: **race/ethnicity recoded** is: Asian + Nat Haw & PI = Asian, Middle Eastern + White = White, Amer Ind & Alaska Nat + Multiple + Other Race = Other Race, Declined + Unknown = Unknown, and Black and Hispanic or latinx are same; **BRP recoded** is: MSM=MSM, MSM PWID=MSM PWID, PWID=PWID, No Risk=No Identified Risk, Sum of all else = Other, **Facility** is clients' last visited facility]*

Goal 1. People living with HIV will have equal rate of viral suppression regardless of race and ethnicity.

Number of Rapid ART start by site

Facility	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
Magnet Express	2	0	0	1	1	2	0	0	2	0
Magnet Strut	57	11	18	22	16	46	24	17	15	1
SFAF - SAS Testing	1	0	1	0	0	0	0	0	0	0
SFAF - 1035 Market	0	0	0	0	0	3	1	2	0	0

Number of Rapid ART start by BRP

BRP	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
MSM	45	5	13	20	15	40	20	15	13	1
MSM PWID	8	4	4	1	0	4	1	2	2	0
No Risk	6	2	1	2	2	6	4	2	2	0
Partner Positive	0	0	0	0	0	0	0	0	0	0
Partner PWID	0	0	0	0	0	0	0	0	0	0
PWID	1	0	1	0	0	0	0	0	0	0

% of Rapid ART by BRP

BRP	1819FY%	1819Q1%	1819Q2%	1819Q3%	1819Q4%	1920FY%	1920Q1%	1920Q2%	1920Q3%	1920Q4%
MSM	0.49	0.11	0.30	0.42	0.31	0.47	0.39	0.30	0.26	0.03
MSM PWID	2.80	3.03	3.15	0.79	0.00	1.45	0.64	1.39	1.53	0.00
No Risk	0.17	0.21	0.09	0.16	0.13	0.18	0.25	0.14	0.13	0.00
Partner Positive	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Partner PWID	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PWID	0.47	0.00	1.09	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TF NoSexMen	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TFSM	0.00	0.00	0.00	0.00	0.00	0.85	0.00	0.00	0.00	0.00
TFSM PWID	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Number of Rapid ART by BRP (recoded)

BRP_recat	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
MSM	45	5	13	20	15	40	20	15	13	1
MSM PWID	8	4	4	1	0	4	1	2	2	0
No Identified Risk	6	2	1	2	2	6	4	2	2	0
PWID	1	0	1	0	0	0	0	0	0	0
Other	0	0	0	0	0	1	0	0	0	0

Number of Rapid ART by Race/Ethnicity

Race/Ethnicity	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
American Indian or Alaska Native	0	0	0	0	0	1	2	0	0	0
Asian	3	1	2	1	0	6	2	2	2	0
Black or African American	6	3	0	4	0	5	2	3	0	0
Declined	2	0	1	1	1	2	1	0	1	0
Hispanic or Latinx	28	3	8	11	9	22	7	9	10	1
Middle Eastern or North African	0	0	0	0	0	0	0	0	0	0
Multiple	1	0	0	1	0	0	0	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0	0	0	0	0	0	0	0
Other Race	0	0	0	0	0	0	0	0	0	0
Unknown	7	1	3	2	3	5	3	2	2	0

White	13	3	5	3	4	10	8	3	2	0

% of Rapid ART by race/ethnicity

Race/Ethnicity	1819FY%	1819Q1%	1819Q2%	1819Q3%	1819Q4%	1920FY%	1920Q1%	1920Q2%	1920Q3%	1920Q4%
American Indian or Alaska Native	0.00	0.00	0.00	0.00	0.00	1.61	4.88	0.00	0.00	0.00
Asian	0.20	0.14	0.30	0.13	0.00	0.40	0.22	0.23	0.23	0.00
Black or African American	0.70	0.83	0.00	0.97	0.00	0.61	0.43	0.72	0.00	0.00
Declined	0.77	0.00	1.10	0.95	0.78	0.71	0.73	0.00	0.72	0.00
Hispanic or Latinx	1.05	0.24	0.67	0.84	0.63	0.80	0.45	0.59	0.64	0.11
Middle Eastern or North African	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Multiple	0.22	0.00	0.00	0.46	0.00	0.00	0.00	0.00	0.00	0.00
Native Hawaiian or Other Pacific Islander	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other Race	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unknown	0.38	0.17	0.44	0.28	0.43	0.37	0.48	0.36	0.37	0.00
White	0.24	0.12	0.21	0.12	0.14	0.20	0.27	0.11	0.07	0.00

Number of Rapid ART by race/ethnicity (recoded)

Race/Ethnicity_recat	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
Other Race	1	0	0	1	0	1	2	0	0	0
Asian	3	1	2	1	0	6	2	2	2	0
Black or African American	6	3	0	4	0	5	2	3	0	0
Unknown	9	1	4	3	4	7	4	2	3	0
Hispanic or Latinx	28	3	8	11	9	22	7	9	10	1
White	13	3	5	3	4	10	8	3	2	0

Number of IART by Race/Ethnicity

Race/Ethnicity	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
American Indian or Alaska Native	0	0	0	0	0	1	1	0	1	0
Asian	4	1	0	1	2	6	4	1	1	1
Black or African American	7	2	1	2	2	10	6	0	3	2
Declined	2	0	1	0	1	7	2	4	1	2
Hispanic or Latinx	34	4	7	9	20	51	17	12	18	13
Middle Eastern or North African	0	0	0	0	0	1	0	0	0	1
Multiple	2	0	0	1	1	6	3	1	1	1
Native Hawaiian or Other Pacific Islander	1	0	0	0	1	2	2	0	0	1
Other Race	1	1	0	0	0	2	1	1	1	0
Unknown	15	4	5	3	6	19	9	4	6	2
White	33	3	6	8	17	34	18	4	10	7

Number of IART by race/ethnicity recode

Race/Ethnicity_recat	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
Other Race	3	1	0	1	1	9	5	2	3	1
Asian	5	1	0	1	3	8	6	1	1	2
Black or African American	7	2	1	2	2	10	6	0	3	2
Unknown	17	4	6	3	7	26	11	8	7	4
Hispanic or Latinx	34	4	7	9	20	51	17	12	18	13
White	33	3	6	8	17	35	18	4	10	8

Number of Virally suppressed by race/ethnicity among HIV+

Race/Ethnicity	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
American Indian or Alaska Native	11	5	5	2	5	6	6	2	4	1
Asian	51	20	23	27	22	51	32	29	32	11
Black or African American	85	44	47	50	47	95	57	54	49	20
Declined	25	13	11	9	11	28	14	15	15	6
Hispanic or Latinx	247	106	118	102	121	260	145	127	137	87
Middle Eastern or North African	1	1	0	1	1	4	1	1	2	2
Multiple	39	23	25	21	18	45	27	29	19	14
Native Hawaiian or Other Pacific Islander	8	4	4	4	3	6	4	5	4	3
Other Race	12	4	2	4	7	9	0	3	6	4
Unknown	91	39	34	36	46	61	38	34	27	16
White	492	235	207	225	246	466	280	243	255	111

% Virally suppressed by race/ethnicity (recode) among HIV+

Race/Ethnicity_recat	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
Other Race	88.57	84.21	86.49	81.82	85.71	88.24	86.84	94.44	85.29	100.00
Asian	83.10	77.42	87.10	79.49	89.29	82.61	80.00	80.95	83.72	70.00
Black or African American	84.16	83.02	82.46	79.37	79.66	80.51	78.08	78.26	76.56	68.97

Unknown	83.45	88.14	88.24	90.00	80.28	79.46	78.79	80.33	77.78	73.33
Hispanic or Latinx	83.45	84.80	81.94	81.60	82.88	81.25	78.80	77.91	83.03	78.38
White	90.29	89.73	90.00	90.40	91.82	91.09	89.49	91.04	91.79	89.68

Number of PLWH with stable housing by race/ethnicity

Race/Ethnicity	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
American Indian or Alaska Native	8	5	4	1	2	4	3	2	4	0
Asian	39	20	17	24	18	50	33	31	34	13
Black or African American	59	27	33	40	40	74	51	42	40	20
Declined	18	8	6	4	9	25	12	13	14	5
Hispanic or Latinx	187	72	95	84	91	214	123	109	115	75
Middle Eastern or North African	1	1	0	1	1	4	1	1	2	2
Multiple	27	20	17	13	11	34	21	20	17	12
Native Hawaiian or Other Pacific Islander	8	4	3	4	3	6	3	4	3	4
Other Race	7	3	1	1	4	4	0	3	3	1
Unknown	68	26	22	16	34	41	22	19	21	11
White	398	203	166	178	195	408	253	209	234	90

% of PLWH with stable housing by race/ethnicity (recoded)

Race/Ethnicity_recat	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
Other Race	8.96	10.98	9.65	6.28	6.59	8.17	8.03	8.56	8.19	7.34
Asian	3.80	3.54	3.36	4.11	3.00	4.25	4.51	4.61	4.47	3.57
Black or African American	13.59	13.57	17.19	17.47	16.60	15.91	19.10	17.14	15.50	13.42
Unknown	13.54	13.82	12.67	7.69	14.33	11.06	10.15	11.15	11.78	10.74
Hispanic or Latinx	10.67	7.82	10.87	8.70	9.31	10.94	10.93	9.73	9.49	10.47
White	10.93	10.00	9.44	9.22	9.64	11.15	11.58	9.98	10.60	7.32

B. Fewer than 100 people living in San Francisco will newly acquire HIV in 2024.

Number of new HIV diagnoses at SFAF

Year	newHIV
1819FY	48
1819Q1	13
1819Q2	12
1819Q3	16
1819Q4	7
1920FY	39
1920Q1	16
1920Q2	11
1920Q3	11
1920Q4	1

Number of HIV-black MSM on PrEP enrollment

Race/Ethnicity	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY_Yes	1920Q1	1920Q2	1920Q3	1920Q4
American Indian or Alaska Native	5	1	2	1	1	1	1	0	0	0
Asian	180	40	42	46	52	112	36	34	29	9
Black or African American	57	15	15	14	13	43	19	4	14	5
Declined	24	8	2	6	8	17	8	6	3	2
Hispanic or Latinx	268	69	49	72	77	210	76	57	50	26
Middle Eastern or North African	5	2	0	0	3	12	5	2	4	1
Multiple	34	12	6	6	10	20	5	9	5	1
Native Hawaiian or Other Pacific Islander	5	1	1	0	3	3	0	0	3	0
Other Race	21	2	10	3	6	9	2	3	3	1
Unknown	78	18	20	15	25	34	22	7	8	1
White	471	159	103	104	105	299	102	80	73	42

% HIV-black MSM on PrEP enrollment (recoded race/ethnicity)

Race/Ethnicity_recat	1819FY%	1819Q1%	1819Q2%	1819Q3%	1819Q4%	1920FY%	1920Q1%	1920Q2%	1920Q3%	1920Q4%
Other Race	12.85	6.22	7.89	4.39	6.80	6.83	3.04	4.53	3.16	1.24
Asian	14.14	5.96	6.81	6.59	7.51	9.38	4.76	4.53	4.28	1.95
Black or African American	14.92	8.29	8.62	6.80	6.81	11.38	8.64	1.84	6.86	3.68
Unknown	14.72	10.16	9.02	6.80	10.93	9.57	9.15	4.55	4.51	2.40
Hispanic or Latinx	15.08	7.42	5.63	7.60	7.82	11.97	7.26	5.44	4.70	3.92
White	12.56	7.98	5.65	5.32	5.39	9.25	5.25	4.09	3.94	3.62

Number of HIV-black MSM on all PrEP (EN, EXP, FU)

Race/Ethnicity	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
American Indian or Alaska Native	9	3	4	2	6	8	3	3	4	2
Asian	497	276	272	308	329	503	327	329	314	108
Black or African American	135	70	76	69	73	127	77	63	76	30
Declined	57	31	25	30	35	63	36	42	30	17
Hispanic or Latinx	726	394	376	417	426	729	455	428	417	191
Middle Eastern or North African	10	7	5	6	8	23	12	15	17	8
Multiple	114	63	65	60	77	112	63	73	64	19
Native Hawaiian or Other Pacific Islander	27	19	19	13	19	25	14	16	14	3
Other Race	56	23	33	27	30	52	29	33	34	4
Unknown	120	49	57	56	68	86	59	52	47	5
White	1394	851	821	857	856	1342	862	860	786	269

% HIV-black MSM on all PrEP (EN, EXP, FU) (recoded race/ethnicity)

Race/Ethnicity_recat	1819FY%	1819Q1%	1819Q2%	1819Q3%	1819Q4%	1920FY%	1920Q1%	1920Q2%	1920Q3%	1920Q4%
Other Race	38.33	36.93	44.74	39.04	45.20	39.18	36.12	41.13	40.32	15.53
Asian	40.06	42.88	46.12	45.99	47.54	43.07	45.11	45.94	43.91	24.08
Black or African American	35.34	38.67	43.68	33.50	38.22	33.60	35.00	29.03	37.25	22.06
Unknown	25.54	31.25	33.61	27.83	34.11	27.95	28.96	32.87	31.56	17.60
Hispanic or Latinx	40.86	42.37	43.17	44.03	43.25	41.54	43.46	40.88	39.23	28.77
White	37.04	42.54	45.33	44.14	43.14	40.61	42.86	43.62	41.05	23.34

% HIV-TGNC on PrEP (enrollment)

TGNC	1819FY%	1819Q1%	1819Q2%	1819Q3%	1819Q4%	1920FY%	1920Q1%	1920Q2%	1920Q3%	1920Q4%
Yes	13.97	11.43	5.76	5.56	6.64	8.70	3.72	6.49	2.88	7.03
No	11.70	6.83	5.78	5.48	6.23	8.29	5.34	3.90	3.91	3.07

% HIV-TGNC on all PrEP (EN, EXP, FU)

TGNC	1819FY%	1819Q1%	1819Q2%	1819Q3%	1819Q4%	1920FY%	1920Q1%	1920Q2%	1920Q3%	1920Q4%
Yes	30.79	31.43	33.51	27.78	29.65	27.33	22.97	29.00	25.10	24.22
No	31.97	38.17	40.64	37.75	38.82	33.06	36.84	37.43	35.58	22.59

% HIV-PWID on PrEP (enrollment)

PWID	1819FY%	1819Q1%	1819Q2%	1819Q3%	1819Q4%	1920FY%	1920Q1%	1920Q2%	1920Q3%	1920Q4%
Yes	7.13	5.45	2.91	4.09	3.65	3.92	3.23	2.30	1.29	1.32
No	12.00	7.09	5.90	5.53	6.35	8.50	5.33	4.07	3.94	3.29

% HIV-PWID on all PrEP (EN, EXP, FU)

PWID	1819FY%	1819Q1%	1819Q2%	1819Q3%	1819Q4%	1920FY%	1920Q1%	1920Q2%	1920Q3%	1920Q4%
Yes	16.95	20.61	16.28	14.62	12.50	16.97	18.43	17.24	16.77	10.53
No	32.54	38.49	41.31	38.16	39.42	33.42	36.82	37.74	35.65	22.98

C. 90% fewer people living with HIV will have hepatitis C because of increased awareness, testing, and treatment.

Number of HCV treatment starts

Year	HCV
1819FY	80
1819Q1	13
1819Q2	24
1819Q3	24
1819Q4	20

1920FY	51
1920Q1	15
1920Q2	13
1920Q3	15
1920Q4	7

Number of people who achieve HCV SVR12

Year	SVR12
1819FY	64
1819Q1	19
1819Q2	14
1819Q3	13
1819Q4	18
1920FY	39
1920Q1	14
1920Q2	9
1920Q3	9
1920Q4	7

% of SFAF clients who are PWID and have had an HCV test ever

PWID	1819FY%	1819Q1%	1819Q2%	1819Q3%	1819Q4%	1920FY%	1920Q1%	1920Q2%	1920Q3%	1920Q4%
Yes	63.79	45.45	43.46	40.17	40.87	58.78	43.26	45.96	42.45	19.09
No	22.28	12.98	13.42	14.26	13.18	21.28	15.21	13.09	12.63	8.39

D. 10,000 overdoses will be prevented or reversed over 5 years because of prevention efforts, including safe injection services.

E. 50% fewer long-term survivors will experience isolation, poor physical health, or unmet mental health needs.

% of SFAF clients age 50+ engaged in medical care Among HIV+

Age	1819FY%	1819Q1%	1819Q2%	1819Q3%	1819Q4%	1920FY%	1920Q1%	1920Q2%	1920Q3%	1920Q4%
13-19	100.00	100.00	100.00	100.00	100.00	80.00	75.00	100.00	50.00	N/a
20-29	89.88	87.50	90.54	93.42	88.89	89.82	88.39	93.41	95.24	84.31
30-39	91.49	94.85	92.52	88.89	92.11	91.42	92.40	91.93	90.85	93.10
40-49	92.47	89.60	93.44	94.87	95.28	89.53	89.44	89.57	91.37	82.46
50+	93.88	94.57	92.80	94.47	96.00	92.75	96.04	93.60	91.37	87.97

% of individuals age 50+ who are virally suppressed (Among HIV+)

Age	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
13-19	100.00	100.00	N/a	N/a	100.00	66.67	0.00	0.00	100.00	N/a
20-29	76.87	82.09	75.38	76.56	79.49	75.32	72.64	78.16	77.50	68.75
30-39	83.83	88.00	83.82	80.00	81.51	81.08	75.76	75.32	80.25	78.82
40-49	87.22	84.17	86.96	86.49	87.80	86.23	88.81	85.59	87.79	81.13
50+	91.29	88.67	91.03	91.67	91.15	91.58	90.42	92.20	90.98	88.59

F. Disparities in sexual health and substance use outcomes among SFAF clients by ethnicity, gender, housing status, and injection behavior will be reduced to 5 percentage points or less.

Number of TGNC seen for sexual health services by site

Facility	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
Aguilas	6	2	1	3	1	4	4	0	0	0
Elizabeth Taylor 50-Plus Network at 1035 Market	0	0	0	0	0	0	0	0	0	0
Magnet Express	122	62	45	54	47	139	77	67	70	0
Magnet Strut	237	92	84	88	111	231	124	98	95	72
Mobile Testing Unit	66	20	25	13	21	75	49	11	20	6
SFAF - 1035 Market	17	7	6	4	6	24	9	13	10	0
SFAF - SAS Testing	13	2	4	2	6	14	9	5	6	1

Number of PWID seen for sexual health services by site

Facility	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3
Aguilas	7	1	0	3	5	6	5	1	0
Elizabeth Taylor 50-Plus Network at 1035 Market	0	0	0	0	0	0	0	0	0
Magnet Express	44	17	20	20	16	44	22	23	28
Magnet Strut	149	63	55	49	56	160	85	59	42
Mobile Testing Unit	68	21	11	19	20	46	21	12	12
SFAF - 1035 Market	19	8	5	2	3	17	3	9	8
SFAF - SAS Testing	151	33	52	34	50	133	58	54	46

Number of BIPOC seen for sexual health services by site

Facility	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
Aguilas	55	14	18	17	18	43	28	8	10	0
Elizabeth Taylor 50-Plus Network at 1035 Market	0	0	0	0	0	0	0	0	0	0
Magnet Express	1332	668	662	658	708	1419	750	862	855	1
Magnet Strut	2601	1182	1087	1268	1241	2506	1410	1235	1187	684
Mobile Testing Unit	659	209	144	212	207	679	268	210	259	132
SFAF - 1035 Market	199	74	60	77	85	209	106	105	93	0
SFAF - SAS Testing	167	40	40	56	57	154	67	65	57	2

Number of NEW sexual health clients who are BIPOC

SHS	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
No	5940	2717	2587	2903	3152	4164	1758	2473	2636	1902
Yes	0	0	0	0	0	1858	1679	869	706	74

% of clients testing for STIs every 3 months by race/ethnicity

Race/Ethnicity / Chlamydia	1819FY_>=3month	1819FY%	1920FY_>=3month	1920FY%
American Indian or Alaska Native	2	5.71	4	10.26
Asian	101	8.68	160	12.33
Black or African American	29	6.11	59	10.73
Declined	15	8.29	22	9.02
Hispanic or Latinx	203	11.12	289	13.28
Middle Eastern or North African	2	11.11	13	15.12
Multiple	27	8.71	43	11.47
Native Hawaiian or Other Pacific Islander	9	11.39	10	11.49
Other Race	15	9.55	15	9.09
Unknown	15	2.79	6	1.41
White	360	9.75	484	12.41
Race/Ethnicity / Gonorrhea	1819FY_>=3month	1819FY%	1920FY_>=3month	1920FY%
American Indian or Alaska Native	2	5.71	4	10.26

Asian	101	8.68	160	12.33
Black or African American	29	6.11	60	10.91
Declined	15	8.29	22	9.02
Hispanic or Latinx	203	11.12	288	13.24
Middle Eastern or North African	2	11.11	13	15.12
Multiple	27	8.71	43	11.47
Native Hawaiian or Other Pacific Islander	9	11.39	10	11.49
Other Race	15	9.55	15	9.09
Unknown	15	2.79	6	1.41
White	360	9.75	486	12.46

Race/Ethnicity / Syphilis	1819FY_>=3month	1819FY%	1920FY_>=3month	1920FY%
American Indian or Alaska Native	5	12.82	4	9.76
Asian	275	20.39	163	12.82
Black or African American	64	11.23	61	11.47
Declined	31	13.60	22	9.21
Hispanic or Latinx	412	19.44	286	13.36
Middle Eastern or North African	7	35.00	12	14.46
Multiple	64	17.34	42	11.20
Native Hawaiian or Other Pacific Islander	16	18.18	10	11.49
Other Race	31	17.13	15	9.32
Unknown	45	7.10	8	1.89
White	839	19.40	469	12.24

Number of people experiencing homelessness seen for sexual health services, by site

Facility	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
Aguilas	3	0	0	2	2	2	2	0	0	0
Magnet Express	4	2	2	6	3	18	7	6	10	0
Magnet Strut	49	11	20	14	21	53	30	20	21	8
Mobile Testing Unit	55	18	12	19	9	41	20	11	9	2
SFAF - 1035 Market	14	4	6	2	3	7	4	2	2	0
SFAF - SAS Testing	127	29	30	40	42	103	46	38	41	0

Number of individuals who had HIV tests by site [HIV test done at SFAF]

Facility	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
Aguilas	83	26	22	28	25	69	45	18	13	0
Magnet Express	2625	1276	1184	1273	1300	2466	1257	1472	1318	2
Magnet Strut	4511	2105	1944	2212	2230	3991	2313	2025	1924	976
Mobile Testing Unit	1052	310	228	339	324	1007	414	302	358	190
SFAF - 1035 Market	337	141	112	136	162	352	201	181	173	0
SFAF - SAS Testing	290	58	75	100	94	262	109	97	92	7

Number of individuals who had HIV tests by BRP [HIV test done at SFAF]

BRP	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
MSM	7256	3500	3171	3506	3575	6396	3663	3503	3236	1034
MSM PWID	166	60	53	64	60	159	80	68	58	19
No Risk	1145	253	244	408	370	1299	460	400	484	97
Partner Positive	15	6	5	5	4	16	5	11	11	2
Partner PWID	44	16	15	19	8	58	27	22	14	3
PWID	154	37	40	36	57	127	56	47	42	2
TF NoSexMen	5	1	1	1	3	9	3	3	2	1
TFSM	90	35	25	31	46	70	40	32	24	14
TFSM PWID	5	1	3	4	2	10	5	4	3	1

Number of individuals who had HIV tests by race/ethnicity [HIV test done at SFAF]

Race/Ethnicity	1819FY	1819Q1	1819Q2	1819Q3	1819Q4	1920FY	1920Q1	1920Q2	1920Q3	1920Q4
American Indian or Alaska Native	33	11	10	14	18	37	20	14	16	5

Asian	1291	590	550	635	631	1200	680	658	603	186
Black or African American	554	206	180	238	211	483	238	205	213	68
Declined	205	97	64	75	87	203	95	105	84	32
Hispanic or Latinx	1899	852	773	910	885	1925	1006	939	939	326
Middle Eastern or North African	19	9	8	6	16	82	29	44	37	21
Multiple	337	156	138	141	156	334	161	160	161	41
Native Hawaiian or Other Pacific Islander	82	42	35	30	40	76	37	40	37	15
Other Race	185	69	76	73	82	152	87	80	70	20
Unknown	564	140	163	220	216	403	228	150	132	27
White	3711	1737	1560	1732	1783	3249	1758	1695	1582	432