**Getting to Zero SF -- Retention Committee Retreat**

**September 18, 2015**

**Project Inform, 273-9th Street, SF 94103**

**NOTES**

*RESULTS-BASED ACCOUNTABILITY FORMAT\**

**What is the result we are working to achieve**?

Assure access to and consistent engagement of HIV-positive San Franciscans in integrated care, treatment and social support to achieve optimal health outcomes and quality of life, as well as to support a reduction in new infections.

**Headline Indicators** *(should: communicate to broad audience; say something of central importance about the result; there is quality data on a timely basis)*

1. Virologic Suppression

* Percent of HIV+ in SF with viral load suppression last 12 months
* Percent of HIV+ in care with viral load suppression last 12 months

2. Retention in Care & Wrap-Around Services

* Percent with 2 HIV care markers (visit, VL, CD4) separated by 90 days in last 12 months
* Percent with (1+ or 2+) missed visits for referred wrap-around service(s)

3. Out of Care & Re-engagement

* Percent of HIV+ in SF with no care marker last 12 months
* Percent identified Out of Care linked to Care within 90 days

**Unmet Need Indicators** *(better metrics need to be developed and refined)*

1. Case Management/Navigation

* Number on rolls with more than 30 day waiting period

2. Housing

* Percent of HIV+ in SF who are homeless
* Percent HIV+ in SF with unstable housing (Shelter, SRO, etc.)

3. Mental Health Services

* Number, percent with prior MH diagnosis or screen+ and no MH visit last 12 months

4. Substance Abuse Services

* Number, % with prior SA diagnosis or screen + and no SAS visit last 12 months

5. Food Security

* Percent of HIV+ in SF reporting any Food Insecurity or Household Hunger (WHO)
* Number waitlisted or ineligible for Project Open Hand services

6. Quality of Life/Care

* Percent of HIV+ in SF with marginal/poor QOL
* Percent of HIV+ in SF reporting poor quality of HIV care

*Important to “layer” populations – consider social determinants for specific populations*

*One approach is for organizations to have the goal of 100% viral suppression for their clients*

**ROOT CAUSES**

* Lack of safe and affordable housing in SF
* Poverty/economic security/income
* Stigma
* Waiting lists for drug treatment programs
* Waiting lists for mental health treatment programs
* Lack of coordinated care and communication
* Food insecurity
* Insurance/health care coverage

**What is the story behind the curve – what is actually happening and why**?

What is contributing to progress – what’s working?

* TLC+
* Focus on housing
* Center of Excellence model
* PrEP
* Strong social support systems
* Group support in client services
* Trauma informed care
* Robust navigation support
* Most clients report satisfaction and would return for services
* Adherence is improving (though we’re still not there)
* Better data – surveillance/data to care/tracking cascade, but we don’t have all the data we need
* Great providers – need to continue supporting them
* Resources, planning & the political will
* Nearly universal care
* Legal services/housing protection
* Clinics as hub for services, one-stop shop
* Vocational rehab & income support services
* Collaboration among providers

What is hindering progress?

* Systems are really hard to navigate; systems need to be simplified and people need help navigating
* Providers are not adequately trained
* Housing issues
* Data limits/multiple systems
* Missed opportunities because of multiple systems and provides not communicating
* Not current with technology – not using cellphones, texting, emailing, social media well
* Insurance churning
* Don’t have simple systems of appointment reminders or maintaining good client contact info
* Really hard to do contact tracing due to apps; people don’t know way people are identifying (HIV status, undetectable, PrEP, etc
* People need to better understand common terms in HIV
* More outreach needed to vulnerable communities
* Providers don’t get reimbursed /outreach
* We lose valuable services & personnel due to $$, end of demo projects, etc.
* Mental health
* Substance use
* Stigma
* Capacity
* Education of HIV+ people about health care

**What works to turn the curve**?

* What current strategies should be continued/scaled up?
* What strategies should be discontinued?
* What new strategies are needed?
* What new strategies address the critical root causes?

*The strategies below were suggested in small working groups; the large group prioritized the strategies, considering the criteria below:*

* Leverage: How strongly will the proposed strategy impact progress?
* Feasibility/reach: Is the proposed strategy feasible?
* Specificity: Is the strategy specific enough to be implemented?
* Values: Is the strategy consistent with the values of the community?

GREEN = first choice

YELLOW = second choice

RED = third choice

**I. CREATING A SEAMLESS HIV SYSTEM OF CARE** *(ANDY)*

* EMRs that are more helpful; advocate for EPIC for all; **GREEEN: 4**; **YELLOW: 4, RED: 2**
* Any door is the right door; support and strengthen **RED: 2**
* More flexibility in care management & coordination in the community as needed **RED: 1**
* Support outreach activities & programs as valued services: **YELLOW: 1**
* Create an information portal at every level
* More access to services that are limited

**II. INCREASED SUPPORT SERVICES** *(DANA)*

* Increase supply of comprehensive services; more money and more resources: **GREEN: 8; YELLOW: 2; RED: 2**
* More peer navigation: **YELLOW: 3; RED: 1**
* Increase incentives for providers and patients to engage **YELLOW: 2; RED: 2**
* More cross-cutting data on need/shortfall: **YELLOW: 1; RED: 1**
* Develop more volunteer systems
* Do a better job helping providers become more aware of what’s available to link to
* Avoid unsustainable services and programs

**III. DATA TO CARE** *(build capacity for others to mine data) (DARPUN)*

* Population based look at data (e.g., VL @ jails, SROs, etc.): **GREEN: 2; YELLOW: 2; RED: 10**
* EPIC for all (cross-cutting); more advocacy: **GREEN: 3; YELLOW: 6; RED: 2**
* Pushing ARIES & DPH; Surveillance accessing ARIES: **GREEN: 1**
* Track and monitor list of people leaving jail, including if they got care: **YELLOW: 1**
* EPIC for all, including advocacy
* Cross reference HIV+ and STD data
* Use existing data better – help clinics identify where else clients get health care (for example, data from Kaiser regarding who lost coverage)

**IV. PATIENT AND PROVIDER/SYSTEMS– COORDINATION & CAPACITY/BUILDING BUILDING ACROSS SYSTEMS** *(health, literacy, and community building; patient respect) (EDWIN)*

* Develop live resource guide -- menu & population specific -- that is easily accessed; e.g., 1 call, 1 APP; Group navigator training and messaging standardized & developed; **GREEN: 7; YELLOW: 3; RED: 1**
* More drop-in space/appointments use waiting time to build community; **YELLOW: 1; RED: 1**
* Bring agencies together for warm hand-offs

**Who are the partners that have a role in “turning the curve”** and how do we ensure that all service providers participate in viral suppression as a key outcome?

* To be discussed once strategies are clearly articulated.

**Next Steps & Wrap-Up**

* Identify “partners” that have a role in turning the curve; discuss strategies to ensure that all service partners participate in viral suppression as a key outcome
* “Data development” – subcommittee to make recommendations for capturing qualitative data and refining the metrics for “unmet need” indicators
* Look to AIDS Housing Plan for some useful metrics
* Consider “Treatment on Demand” approach/models for substance use and mental health