

A wide-angle photograph of the San Francisco skyline at sunset. The Golden Gate Bridge's red-orange towers and suspension cables are prominent in the foreground, framing the view. The city's dense urban landscape, including the Transamerica Pyramid, is visible in the background under a soft, hazy sky.

# Centers of Excellence Services Overview

# San Francisco's Care Model

## A Comprehensive Service Delivery System

### Centers of Excellence

- Design a system to respond to needs according to race, gender, geographic, linguistic and cultural needs for communities impacted by **health disparities**
- CoE offer **integrated access** to primary medical care and critical support services
- Allocated funding for CoE **proportionate to client demographics**
- Funding for models that offered innovative and effective approaches to reaching individuals not in care and **bringing them into care** and **maintaining treatment and adherence to medication regimens** over time
- Many CoE's represent a **partnership** between university, community, and public health service providers

# CoE's Culturally Competent Services

- This approach culminated in a significant intensification of the integrated services model in the form of the EMA's seven **Centers of Excellence –“one stop shop community center”** programs similar to medical homes with wraparound services
  - work toward the goal of stabilizing the lives of multiply diagnosed and severe need populations
  - through neighborhood-based, multi-service centers
  - tailored to the needs of specific cultural, linguistic, and behavioral groups
- Centers of Excellence programs form a cost-effective system in which
  - **multidisciplinary teams** provide high levels of HIV specialist medical care
  - integrated with medical case management, mental health assessment, referral and/or brief counseling, substance abuse assessment, counseling and referral, treatment advocacy, psychiatric consultation and medication monitoring, care coordination, vouchers for transportation, clothing and household goods

# San Francisco's Evolution of CoE's

- The **Center of Excellence** model was initially conceived in **2003-2004**, with services put out to bid via an RFP in **late 2005**
- A Work Group was convened, comprised of HHSPC members, service providers and HIV Health Services staff to look the then **Integrated Service Model** programs and evolve toward Centers of Excellence
- CoE services were put out to bid a second time in **2010** and included **Prevention with Positives** (PWP) services, funded through the HIV Prevention Section. Five of the seven CoE now have funding for these PWP specific services
- Lead service provider agencies and subcontractor collaborators providing CoE services and have remained **very consistent** through the **9+ years** of program implementation
- All CoE programs partner with HIV Emergency Housing community services for rapid and prioritized referral

# Requirements from 2010 CoE Solicitation

- CoE model establishes primary medical care at the center of an integrated service delivery model that must provide at a minimum:
  - Primary Medical Care
  - Medical Case Management
  - Psychiatric Assessment and Psychiatric Medication Monitoring
  - Treatment Adherence and Medication Assistance
  - Outpatient Mental Health, Substance Use Assessment, Counseling and Referral

# Definition of CoE Target Populations

- Centers of Excellence were established to serve severe need clients and special target populations
- To qualify as “Severe Need” a client must meet all of the following criteria:
  - Disabled by HIV disease or with symptomatic diagnosis
  - Active substance abuse or mental illness
  - Living with adjusted gross income equal to or less than 150% of federal poverty level



# Definition of CoE's Target Populations (continued)

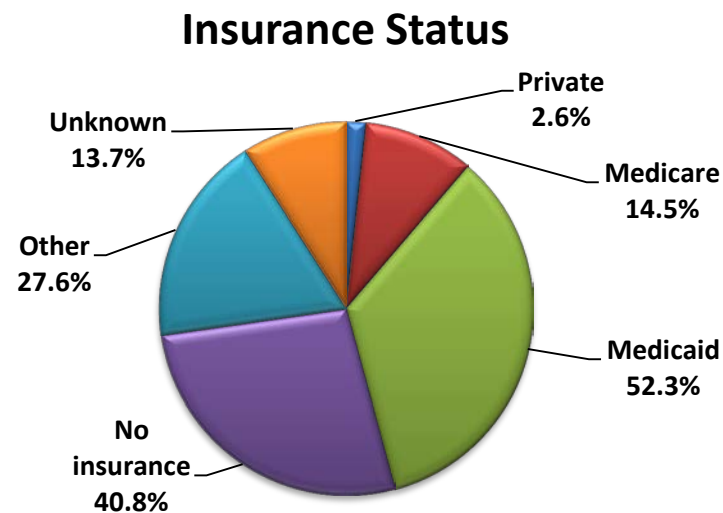
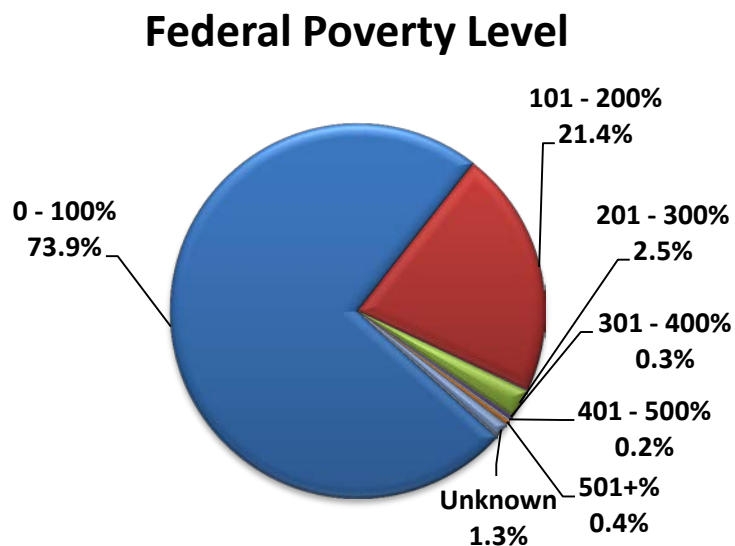
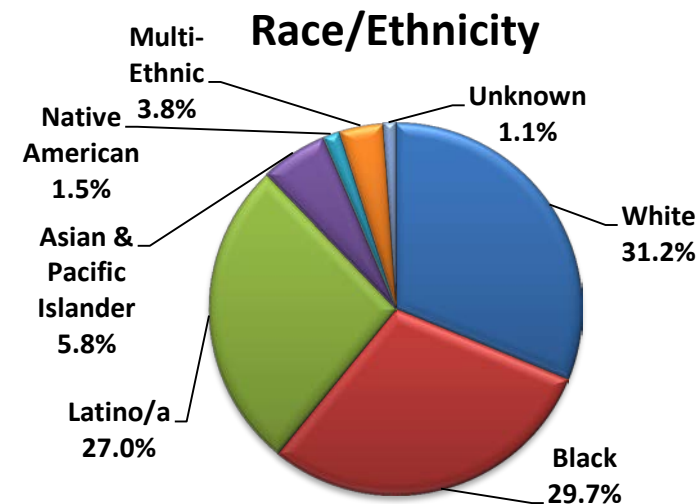
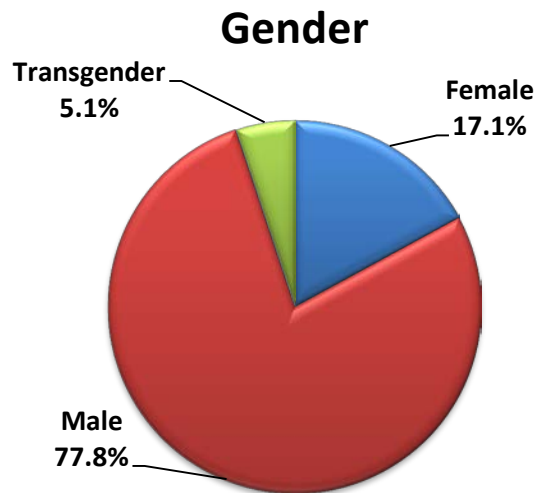
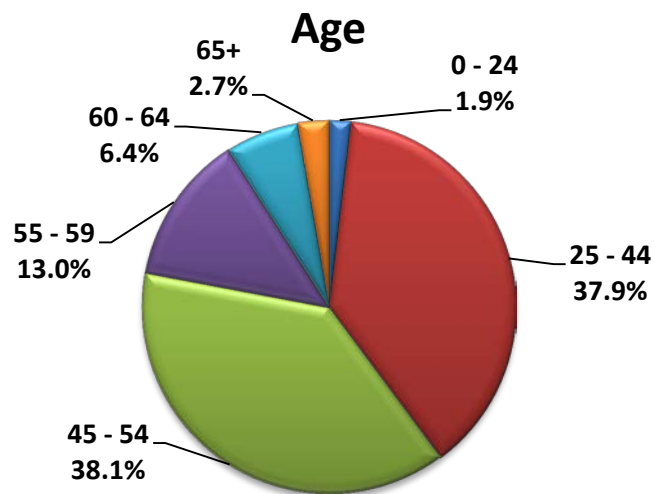
- **Special populations have unique or disproportionate barriers to care, may need additional or unique services, or require a special level of expertise to maintain them in care, including:**
  - Individuals who identify as Transgender
  - Populations with the lowest rates of use of antiretroviral treatment (e.g., women, African Americans, and IDU)
  - Communities with linguistic or cultural barriers to care, including immigrants, as well as monolingual Spanish speakers
  - Individuals who are being released from incarceration in jails or prisons, or those with a recent criminal history
  - Persons living with HIV/AIDS who are 60 years of age or older

# Center of Excellence Summary

- All **Center of Excellence** programs have developed services and program culture to better adapt to serve **specific high risk communities** with **unique needs**
- **Health disparities** exist nationally where **communities of color** are more **heavily impacted** with lower levels of **viral load suppression** and being on **ART**. **However, in San Francisco, likely due to the work of the CoE's, ARIES data indicates no disparities exist for those engaged in care.** Disparities still exist nation-wide and for S.F. patient's intermittently engaged in care and not in care
- Center of Excellence programs has a minimal amount of client (<2%) who are seen in more than one CoE in the measured year (likely from HIV-IS)
- **Behaviorally complex** clients continue to be a **challenge to serve**

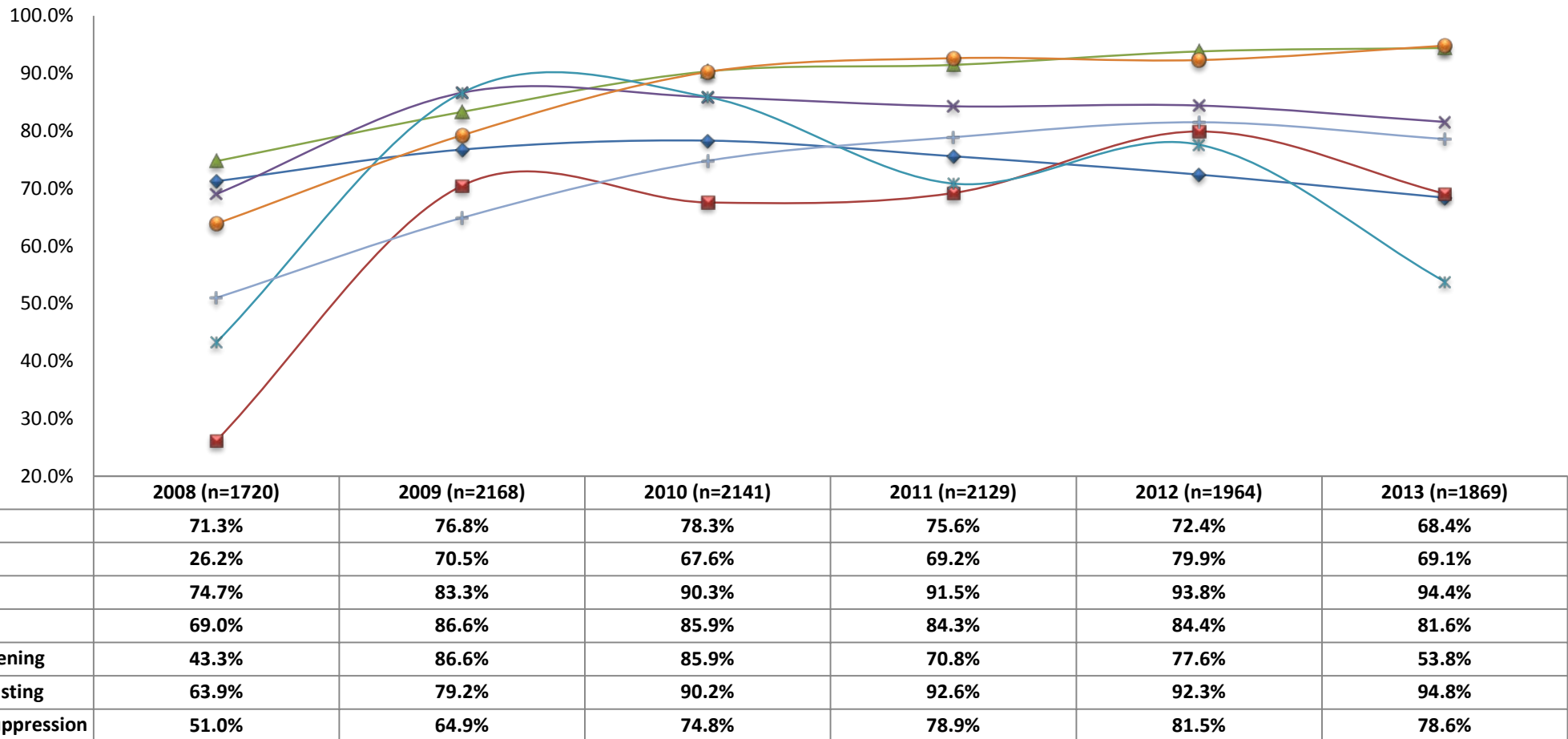


# CoE Aggregate - Demographics

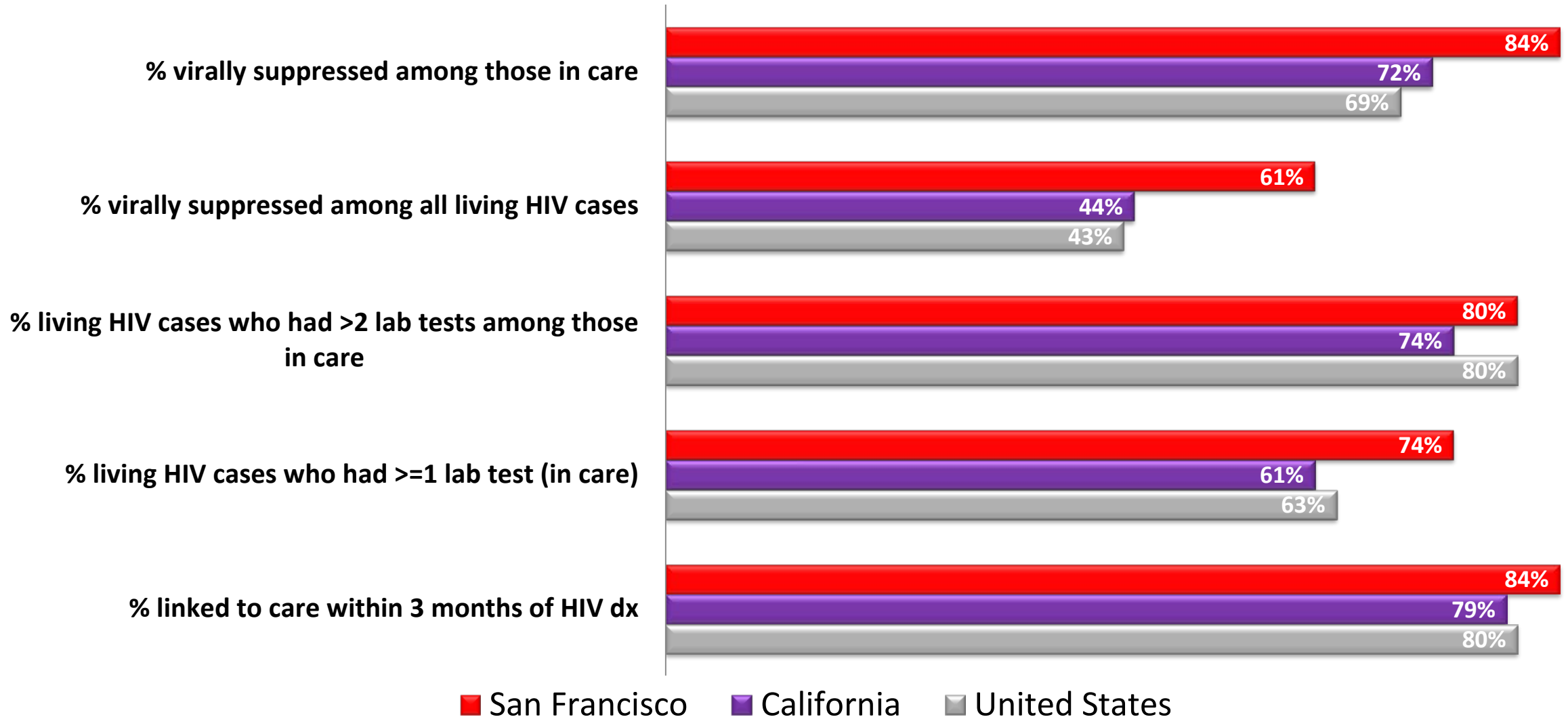


# San Francisco's Centers of Excellence Performance Trends

SF CoE Performance Indicators 2008-2013



# Percentage Comparison of HIV Care Indicators for **San Francisco** , **California** , and **United States** , 2010

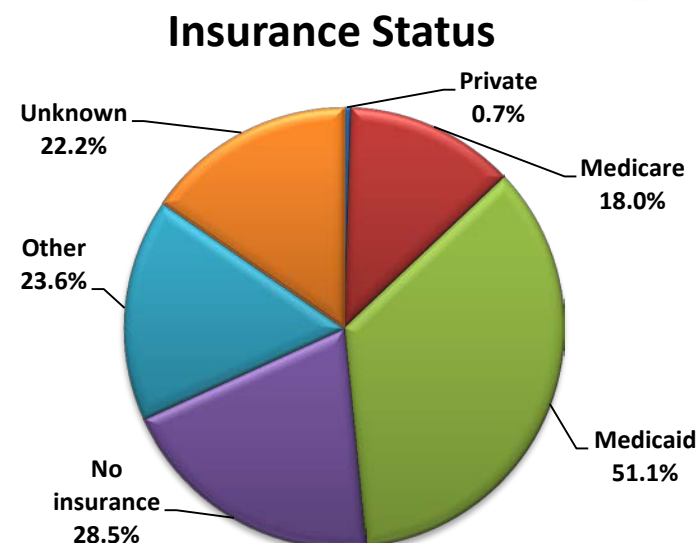
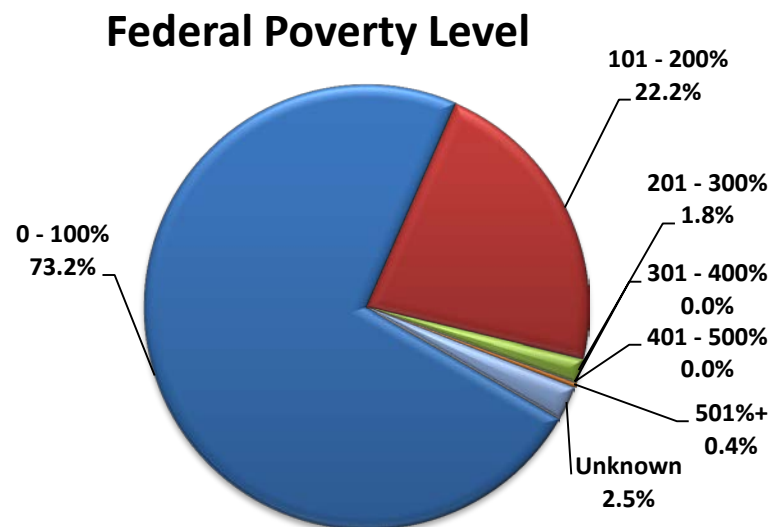
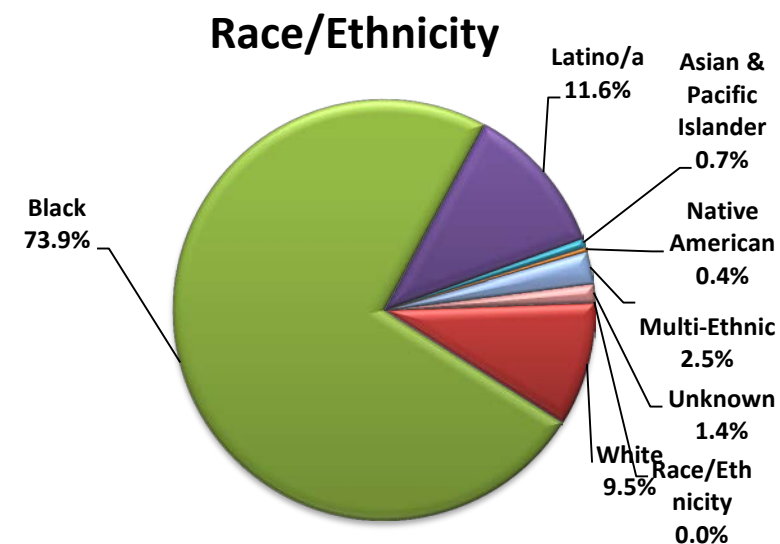
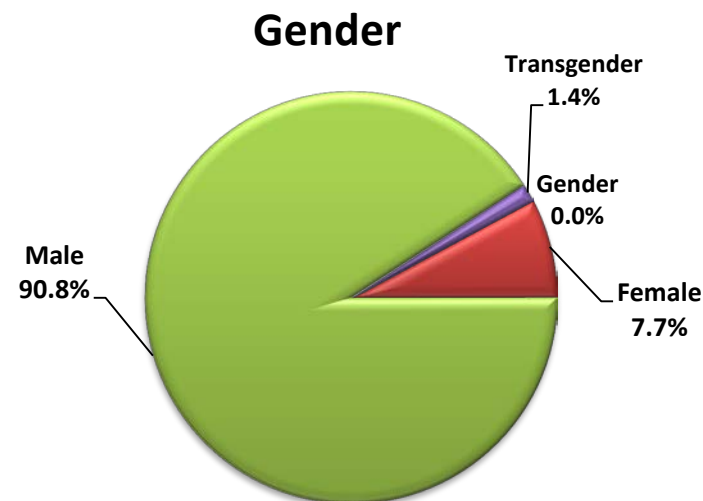
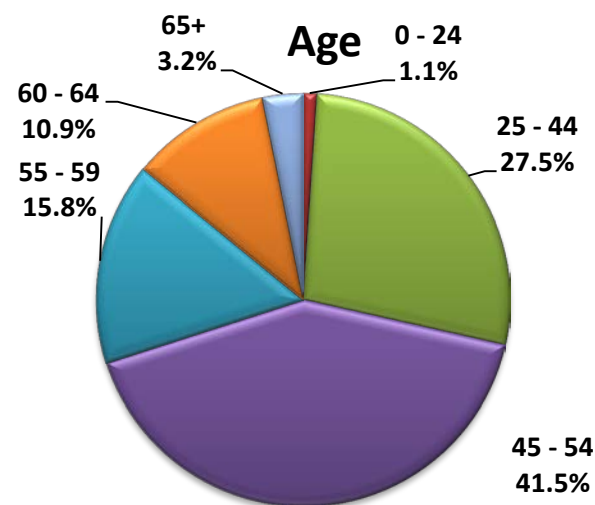


# Black Health Center of Excellence

ARIES DATA	2013-14 MEDICAL UOS	2013-14 MED. CASE MANAGEMENT UOS	2013-14 OTHER PROVIDED UOS	2013-14 UDC TARGET	2013-14 UDC DELIVERED
	1,905 (<7 Visits Per Client)	3,506 (12 Hours Per Client)	2,915	210	284

- UCSF / Positive Health Program is the Lead Agency
- Partners include UCSF's Positive Care Center/ aka Men of Color Program (Parnassus campus) and the San Francisco AIDS Foundation. DPH Southeast Health Center participates through the Executive Committee leadership meetings of the CoE.
- Targeting African-American men and women living throughout the City. Populations include persons disabled by HIV infection or with symptomatic HIV diagnosis, active substance users, have mental health issues, living under 150% FPL, are transgender identified, non-gay identified MSM, infected individuals unaware of their status, affected young people with HIV infected parents, caregivers and families
- Prevention with Positives (PWP) services offered through CDC prevention funds

# Black Health CoE - Demographics



# Black Health CoE

The Black Health CoE places a strong emphasis on culturally appropriate interventions including community building and social support to combat stigma and isolation related to HIV amongst African Americans

- Numerous social support and psycho-educational groups throughout the week at The San Francisco AIDS Foundation
  - Black H.O.P.E. (Healthy Outcomes for Prevention and Education)- A harm reduction and recovery model rooted in African American History and the African American experience
  - Crystal Clear- Harm Reduction Support group for black MSMs with a history of crystal meth use.
  - Trans-Life- A Transgender Support, Psycho-educational, and Empowerment Group
  - Freedom Fridays- A Support and Empowerment Group focused on setting healthy goals and reducing harm in all areas of functioning
- Quarterly “Positively Black” Socials that feature food, dancing, and games as well as a presentation from a community partner highlighting a social service agency in the community. All Black Health CoE clients are invited to the Positively Black Social to facilitate interaction and community connection with other Black Health CoE Clients

## Dad & Baby



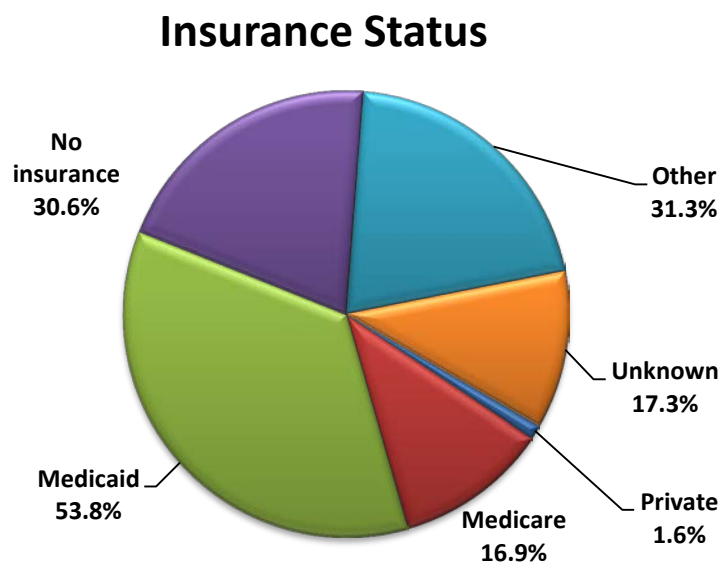
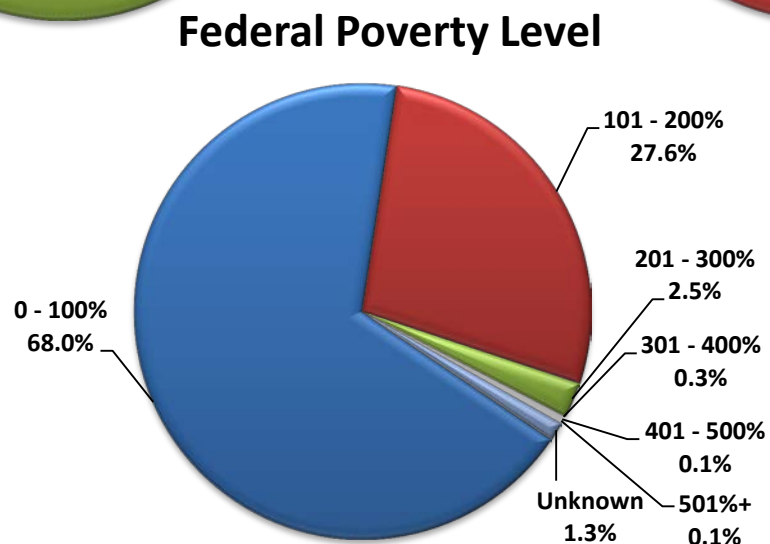
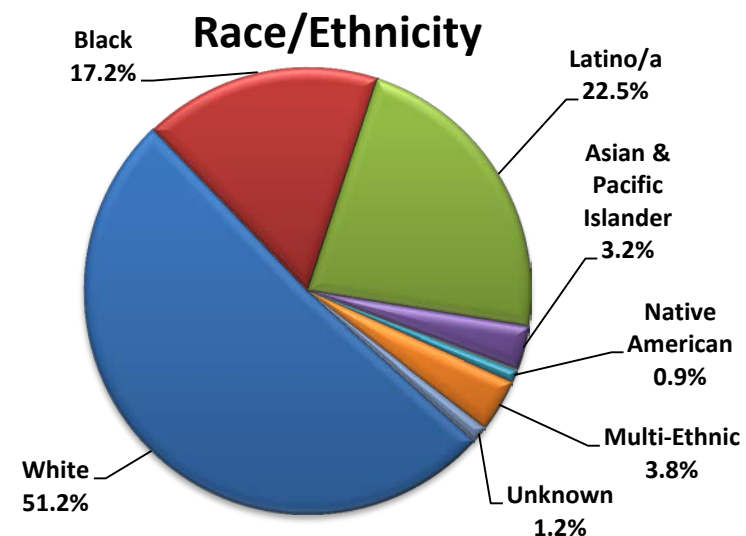
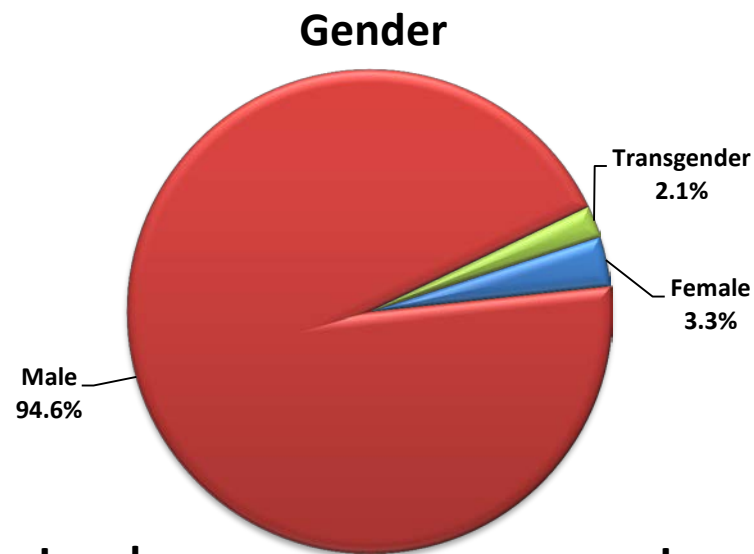
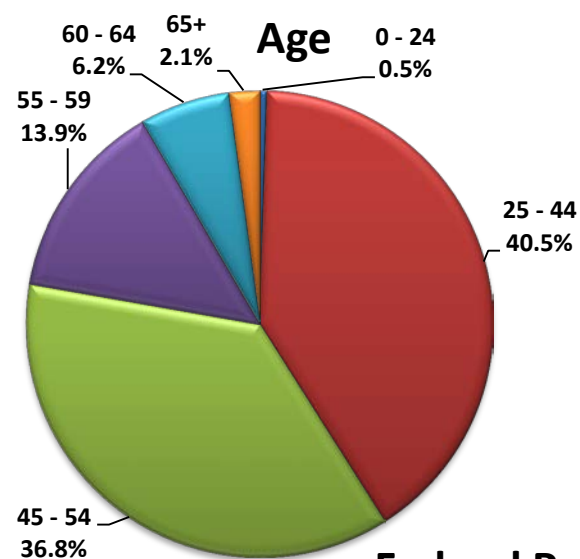


# Chronic Care HIV/AIDS Multidisciplinary Program Center of Excellence (CCHAMP CoE)

ARIES DATA	2013-14 MEDICAL UOS	2013-14 MED. CASE MANAGEMENT UOS	2013-14 OTHER PROVIDED UOS	2013-14 UDC TARGET	2013-14 UDC DELIVERED
	2,932 (5 Visits Per Client)	4,768 (6 Hours Per Client)	3,939	600	597

- UCSF / Positive Health Program is the Lead Agency
- Partners include the Alliance Health Project, UCSF's Substance Treatment Outpatient Program (STOP) and the San Francisco AIDS Foundation (Stonewall)
- Services provided to individuals living in poverty and for whom mental health disorders, substance abuse, incarceration or housing status create barriers to care
- Primary care provided at SFGH, with supportive services available at SFGH and the Mid-market area. Includes access to medical specialty clinics for individuals with advanced disease and co-morbidities, individuals who have limited access to and/or difficulties remaining engaged in care
- Prevention with Positives (PWP) services offered through CDC prevention funds

# CCHAMP CoE - Demographics



# CCHAMP CoE

- **Program specific highlights, strengths, and challenges**
  - Strength: Creation of a medical home (access - 5 days/week)
  - Strength: Urgent Care (access - 5 days/week)
  - Strength: Hospital Admission (patient is easily admitted from the clinic directly to hospital)
  - Strength: Access to hospital based specialties
  - Challenge: Space (Flexibility of community partners, but moving to inpatient hospital in 2016)
- **Best practices in service provision**
  - Sub Use, Mental Health, Case Mngmt, Primary Medical & Psychiatry all under one roof (& off-site location)
  - Prevention CM (CDC funded)
  - Behaviorist (MAI-TCE funded)
  - Electronic Medical Record (team approach: each discipline (SU, MH, CM, PM, Psych) all charts in the same EMR)
  - CM Summit (almost quarterly of sharing best practices within COE's)
- **CAB participation / Coordination meetings**
  - Executive committee (monthly)
  - Case conferences (monthly)

## Two CCHAMP Champs!



# Patient & Provider





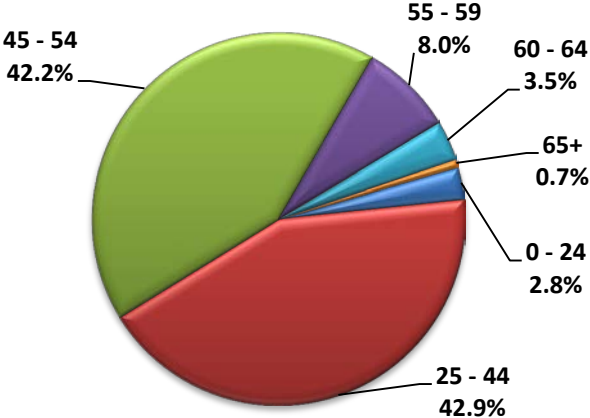
# HIV Integrated Services (HIV-IS)

ARIES DATA	2013-14 MEDICAL UOS	2013-14 MED. CASE MANAGEMENT UOS	2013-14 OTHER PROVIDED UOS	2013-14 UDC TARGET	2013-14 UDC DELIVERED
	1,953 (7 Visits Per Client)	295 (1 Hour Per Client)	0	225	287

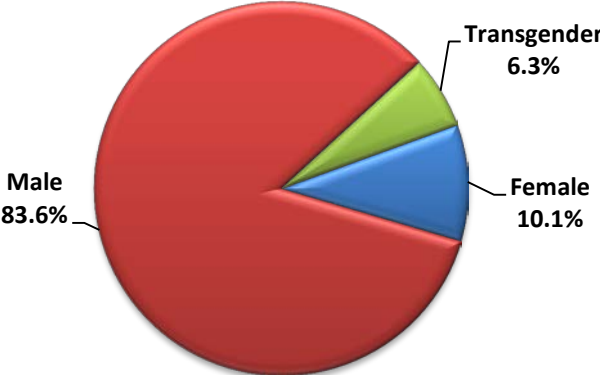
- SF DPH HIV Integrated Services (formerly known as Forensic AIDS Project) is the stand alone Lead Agency
- The target population is HIV positive men, women and transgender individuals in custody in the San Francisco City and County jail system.
- Case management focused services target HIV positive men and women in the San Francisco County Jails who are returning to the Tenderloin, South of Market Sixth Street corridor, the Mission and Bay View-Hunters Point neighborhoods.

# HIV-IS CoE - Demographics

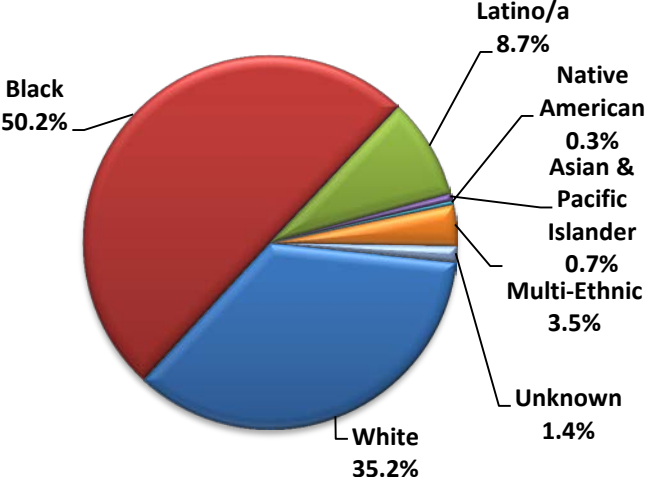
Age



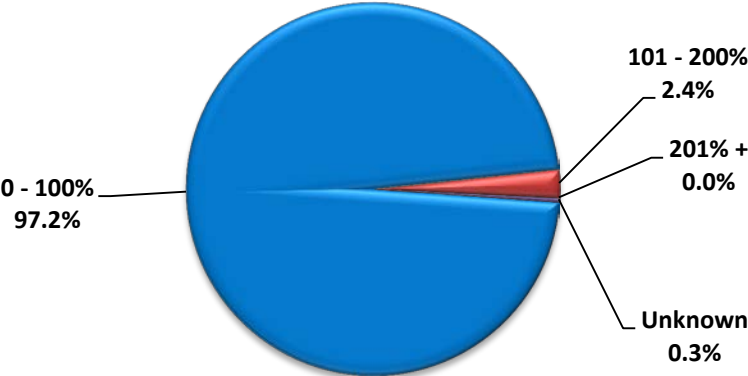
Gender



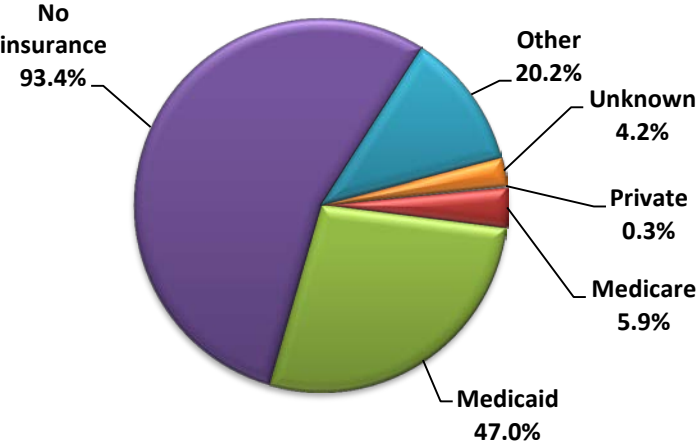
Race/Ethnicity



Federal Poverty Level



Insurance Status





# HIV-IS CoE

- In 2013:
  - Tested 3,713 county jail prisoners tested for HIV
  - Identified 13 new positives, all of whom were linked into HIV primary care. 11 were linked into the HIV-IS Center of Excellence within 24 hours of diagnosis, the other 2 were linked into community care at discharge
  - Tested 2,333 incarcerated men and women for hepatitis C; 9% of those tested required further testing and possible treatment
  - Provided overdose education to 167 prisoners of whom 62% received narcan kits upon release

# HIV-IS CoE

- In 2013, the HIV-IS Center of Excellence (CoE) team provided 504 HIV+ prisoners with primary HIV care and education, discharge planning and post release case management
- HIV-CoE Case Managers start making discharge plans with HIV+ clients when they come into the jails
- When someone entering the San Francisco jails is identified as HIV+ either by self-disclosure or by past history or testing, they are evaluated and seen by CoE clinical staff within 5 days
- Newly diagnosed HIV+ prisoners are linked into primary care within 24 hours of diagnosis. They are seen by the HIV-CoE MD or RN
- CoE clients, upon release from jail, leave with a week's supply of medications, a primary care appointment, food vouchers, housing referrals and drug and alcohol referrals as needed and prescriptions for 1 month of anti-retrovirals and other medications

# HIV-IS CoE

- While the jail population has been dropping at the rate of 5% a year in recent years, HIV-IS is seeing an increasing number of extremely medically complex patients who combine an HIV diagnosis with anger and violence. The result is that they may be denied services in community based programs where the safety of staff or other clients may be an issue
- Jail has become the de facto provider of last resort for these clients. However, these clients do not remain in custody forever, thus, CoE providers are left trying to find suitable alternative placements for violent HIV+ clients who no longer have access to safety net services.
- This population requires services for HIV in combination with **behavioral** health services at a higher skill level than many of our centers offer.

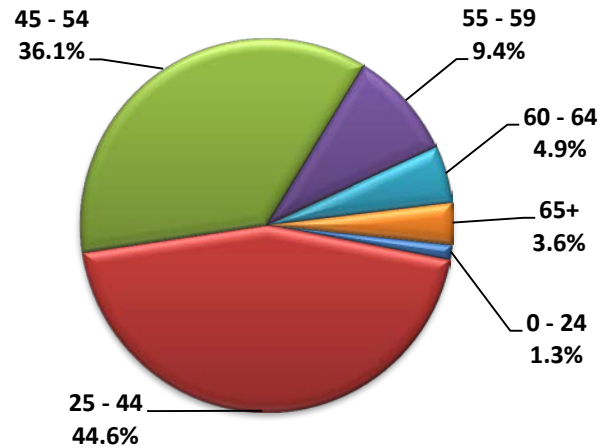
# Mission Center of Excellence

ARIES DATA	2013-14 MEDICAL UOS	2013-14 MED. CASE MANAGEMENT UOS	2013-14 OTHER PROVIDED UOS	2013-14 UDC TARGET	2013-14 UDC DELIVERED
	1,370 (3 Visits Per Client)	2,969 (7 Hours Per Client)	3,574	325	446

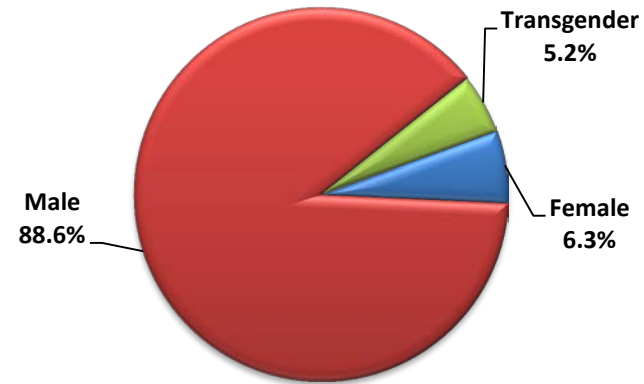
- Mission Neighborhood Health Center is the Lead Agency
- Instituto Familiar de la Raza is the partner agency
- Array of services provided linked to primary care
- People of Color targeted, particularly non-gay identified Latino MSM, Latina Transgender women and their sexual partners, severe-need HIV positive immigrants who are monolingual Spanish-speaking or have limited English
- Partially funded with Minority AIDS initiative funds
- Prevention with Positives (PWP) services offered through CDC prevention funds

# Mission CoE - Demographics

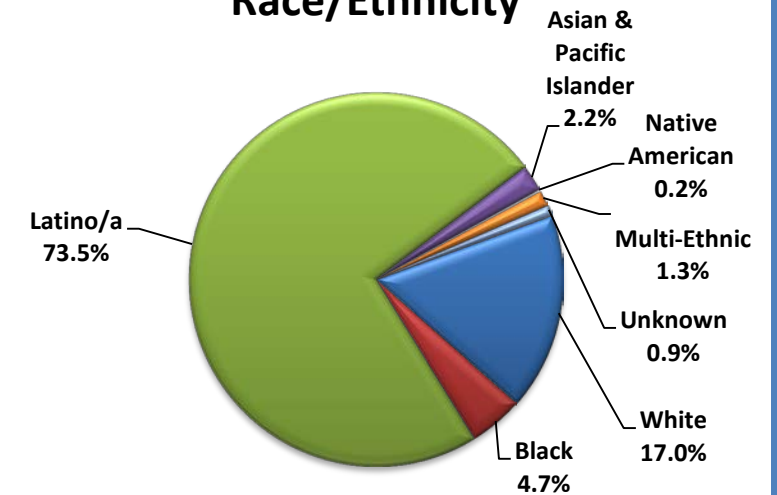
## Age



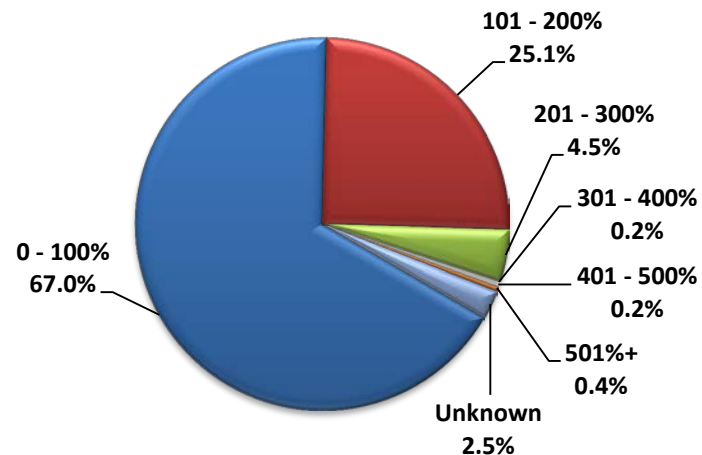
## Gender



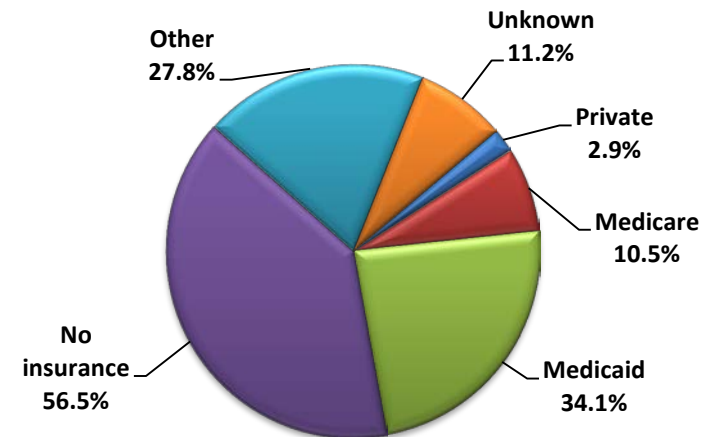
## Race/Ethnicity



## Federal Poverty Level



## Insurance Status



# Mission CoE

## Highlights of Mission CoE:

As part of our commitment to provide services of HIV care, treatment, prevention and support we have developed various Innovative strategies:

- A Recruitment and Retention strategy; that includes a close follow up with clients to maintain an engaged care
- A Special linkage dynamic outreach effort for clients newly diagnosed, out of care or endanger of falling out of care
- Cultural competence; providing culturally and linguistically appropriate services

## Our Main Challenge:

A majority of our clients have housing issues; instability or are homeless; this coupled to the fact some clients have no access to a phone can really complicate contact and therefore engagement in their own health care

# Mission CoE

## Best Practices:

In an effort to maintain high quality services, one of our best practices is to take a data-driven approach; using population management software, to measure the success and challenges in a fashionable manner

Updating our staff with training and according to the need of our client population, High viral loads among substance users prompted we hired a Substance Abuse Counselor through our subcontractors Instituto Familiar de la Raza

## CAB participation / Coordination meetings:

As a way to promote communication and engagement among providers and clients we have Weekly staff meetings, where we discuss ways to improve services and address any concerns with clients

Mission Neighborhood Health Center has a CAB/ Board of Directors, 50 % of which are clients, which oversees all services, including Clinica Esperanza

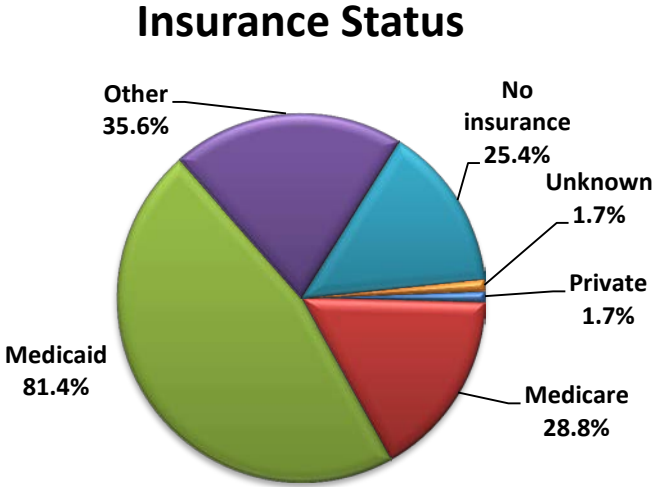
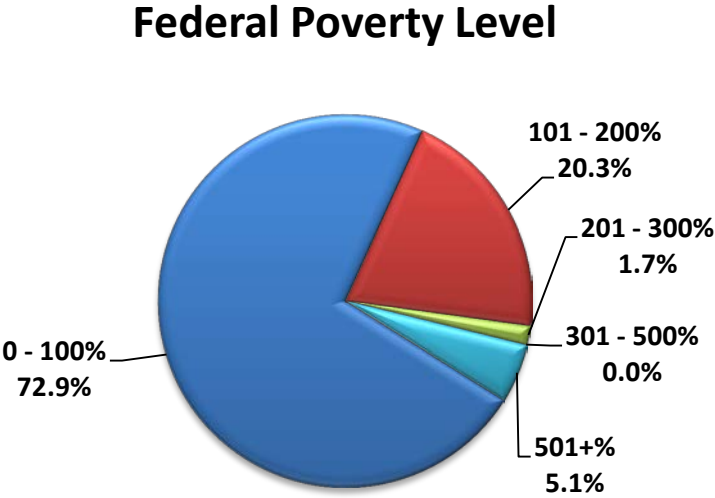
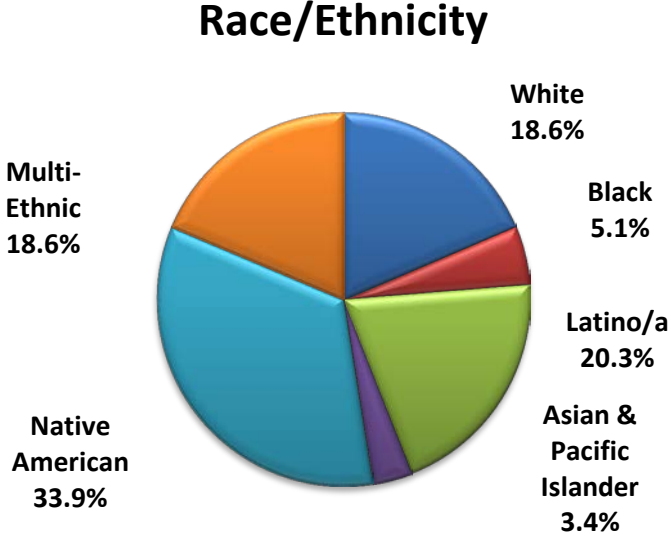
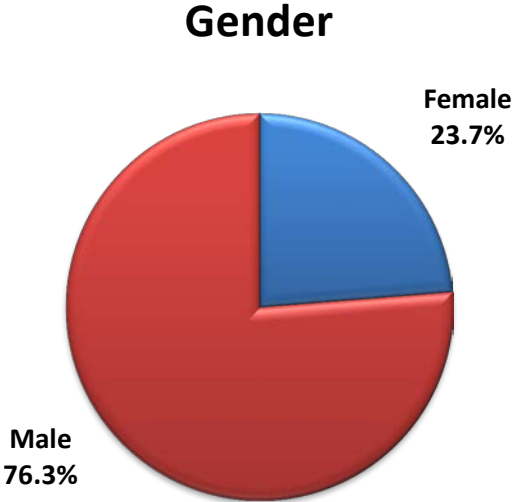
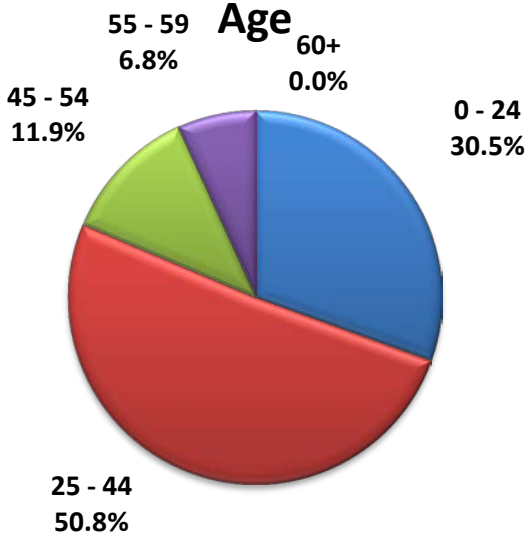


# Native American Center of Excellence

ARIES DATA	2013-14 MEDICAL UOS	2013-14 MED. CASE MANAGEMENT UOS	2013-14 OTHER PROVIDED UOS	2013-14 UDC TARGET	2013-14 UDC DELIVERED
	399 (<5 Visits Per Client)	225 (3 Hours Per Client)	3,382	40	83

- Native American Health Center is the stand alone Lead Agency
- Located in the Mission and Mid-Market areas providing an array of services linked to primary care
- Targeting Native Americans with a special emphasis on MSM
- Prevention with Positives (PWP) services offered through CDC prevention funds

# Native American CoE - Demographics



# Native American CoE

- **Success:**
  - All members are successfully referred to and enrolled in insurance and/or treatment coverage: Care Coordinators are enrollment workers for ADAP and CCA.
  - None of our CoE patients are lost to follow-up
  - Assisting clients with successfully achieving goals for sobriety and improved mental health
  - Successfully integration of databases using our EHR system (NextGen)
  - NAHC set up with trained ACA enrollment workers, able to enroll individuals on site; also rolled out NextGen, our electronic health records system which support us in ACA efforts at all of our sites (SF, Oak, Richmond)

# Native American CoE

- **Challenge:**
  - Housing referrals and accessibility to housing, including sober living spaces
  - Completion of annual screening / immunization activities, such as for TB, Syphilis and Influenza
  - Keeping clients in housing despite substance abuse and severe mental health issues
  - There is a gap in services: between clients waiting to get into a residential program and are currently homeless (and using, might need a detox space)
  - Although NAHC is a clinic, it is also perceived by the community as a cultural center, at times there are limitations to supportive social/cultural environment and/or activities, NAHC can offer and maintain confidentiality for its members accessing services
  - On-going need to clarify costs to clients and populations served: (1) NAHC, while striving to reach out and offer services to Native Americans, welcomes everyone (it is not exclusively for NA/AN), and (2) for those who identify as NA/AN, we do not automatically offer services free of charge
  - There is a serious lack of space for all services required (and desired)

# Native American CoE

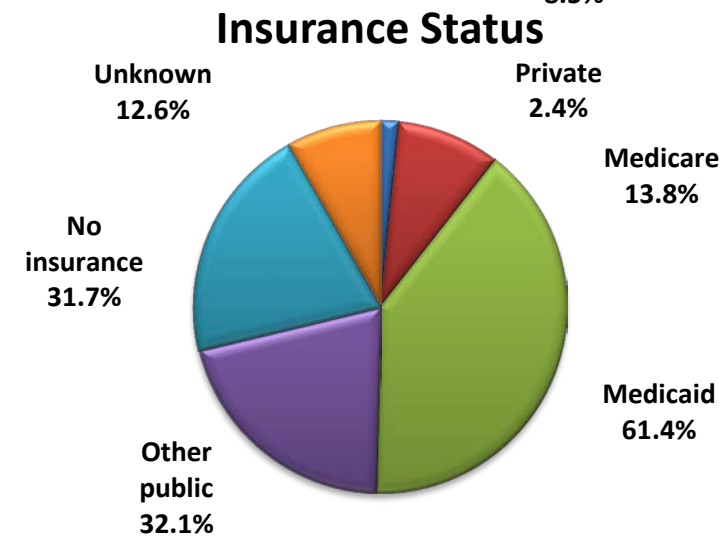
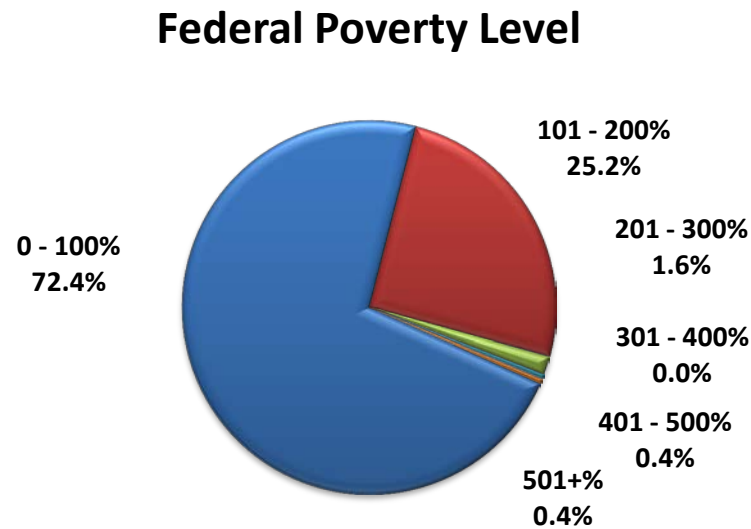
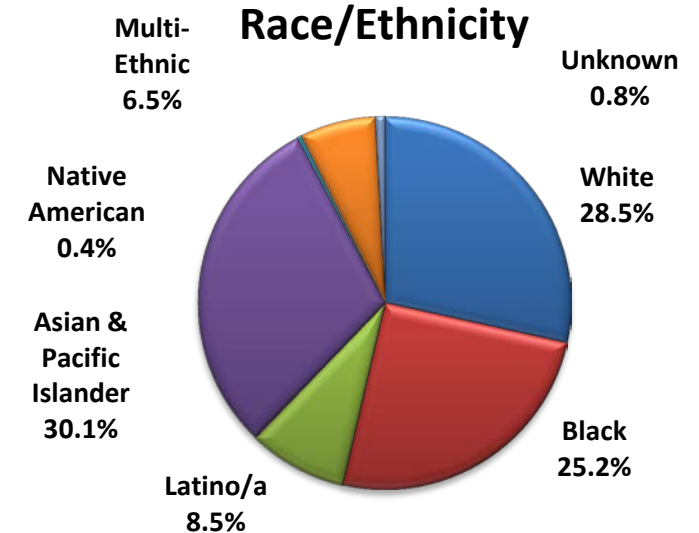
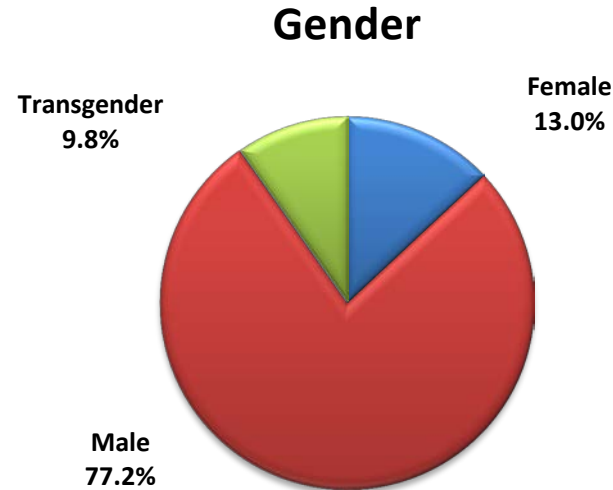
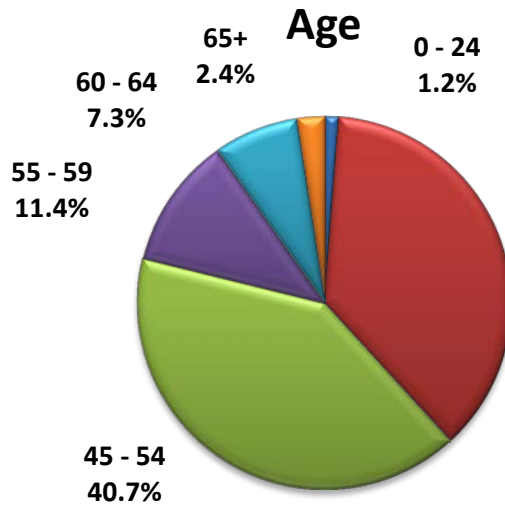
- **Best Practices:**
  - Care Coordinator is the first point of contact and can schedule appointments agency-wide
  - Analyzing and distributing results of annual Client Satisfaction Survey among CoE staff
  - Through an ongoing assessment of clients' risk, presenting substance abuse and mental health concerns (that include trauma and medical issues), helping them to prioritize their needs to support them in keeping stable housing
  - Our CoE is unique to our population (i.e, bringing traditional consultants to help clients with medication/treatment adherence, emphasizing integration of western and traditional practices, such sweat lodges, nutrition classes geared towards appreciating traditional foods, blessing of the meds, etc.

# Tenderloin Area Center of Excellence

ARIES DATA	2013-14 MEDICAL UOS	2013-14 MED. CASE MANAGEMENT UOS	2013-14 OTHER PROVIDED UOS	2013-14 UDC TARGET	2013-14 UDC DELIVERED
	2,633 (>10 Visits Per Client)	5,301 (22 Hours Per Client)	5,993	300	247

- Asian & Pacific Islander Wellness Center is the lead agency
- DPH Tom Waddell Health Center provides medical care
- Two sites located in the Tenderloin area with emphasis on multiply-diagnosed and harm reduction services
- Targeting Homeless and Marginally housed, Transgender and Asian Pacific Islander in 94102 and 94103 zip codes
- Other populations include active substance users, those coping with mental illness, sex workers, non-English speaking and gay males and non-gay identified partners
- Prevention with Positives (PWP) services offered through CDC prevention funds

# Tenderloin CoE - Demographics





# Tenderloin Area CoE

- **Program specific highlights, strengths, and challenges**
  - Highlights and Strengths: Homeless Health Outreach and Mobile Engagement program (HHOME) is a HRSA Special Project of National Significance (SPNS) that delivers mobile medical and supportive services to homeless populations and links them to the COE
  - Challenges: Maintaining timely access to primary care clinic appointments during conversion to new Electronic Medical Record (ECW) and primary care clinic staff shortages. Ongoing challenges with data access and connectivity
  - COE offers a growing array of behavioral health services, including weekly individual therapy, art groups, relationship groups and other groups. COE is expanding its collaboration for auxiliary mental health services with UCSF and USF
  - There is a shortage of availability to psychiatric medication and treatment hours

# Tenderloin Area CoE

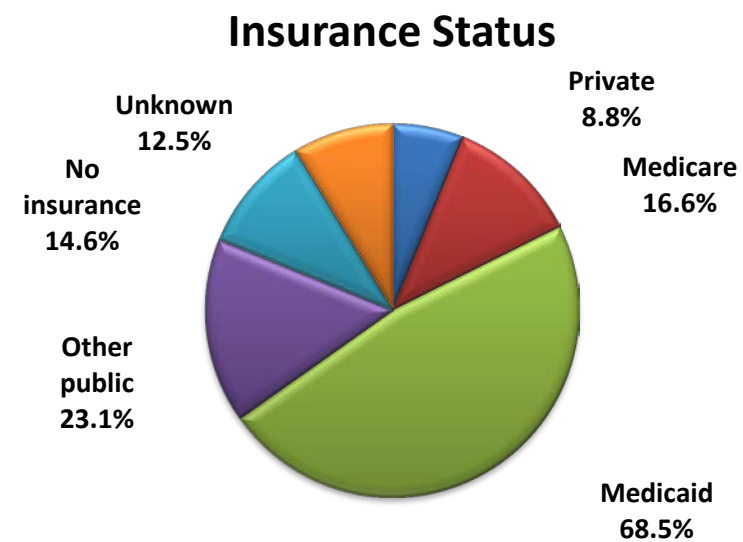
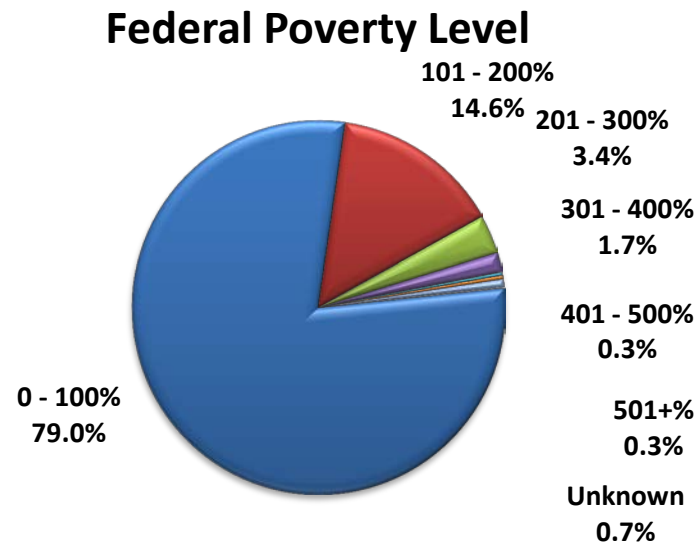
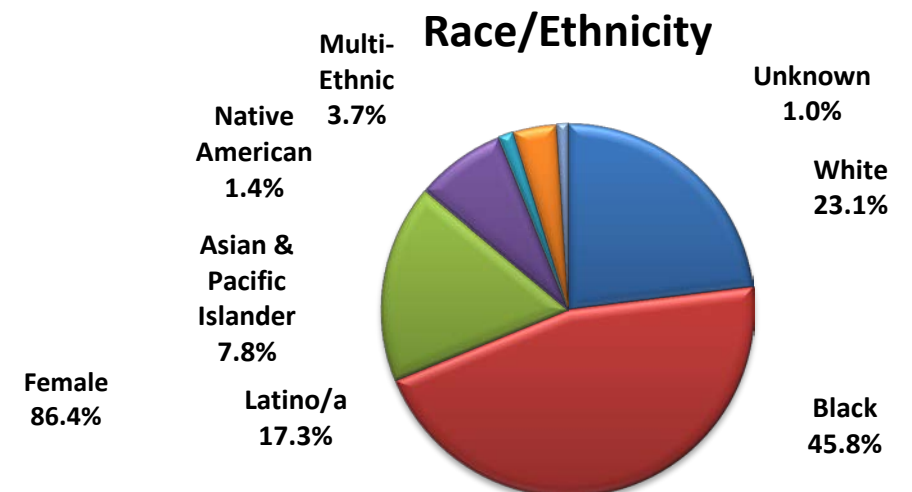
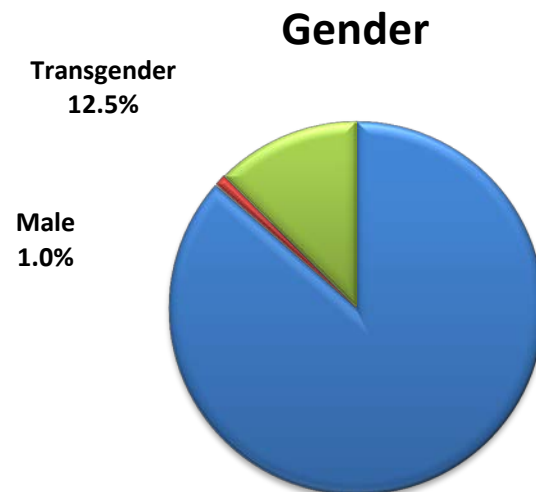
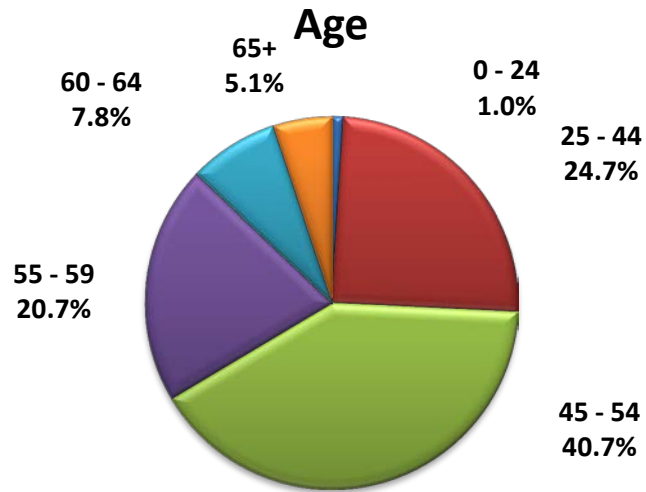
- **Best practices in service provision**
  - COE drop-in center weekday mornings provides ready access to case managers, snacks and social opportunities
- **CAB participation / Coordination meetings**
  - Third Tuesday of each month at 1:30 p.m.

# Women's Center of Excellence

ARIES DATA	2013-14 MEDICAL UOS	2013-14 MED. CASE MANAGEMENT UOS	2013-14 OTHER PROVIDED UOS	2013-14 UDC TARGET	2013-14 UDC DELIVERED
	1,047 (3.5 Visits Per Client)	4,083 (14 Hours Per Client)	6,575	240	295

- UCSF / Positive Health Program is the Lead Agency
- Partners include UCSF's Women's HIV Program, Catholic Charities (Rita de Cascia), and South Van Ness Adult Behavioral Health Services
- Addresses the medical and psychosocial needs of women with HIV. Target population is women of color, primarily African-American, recently incarcerated, Latinas and transgender women
- Medical and wrap-around services available at two sites: SFGH/ UCSF Positive Health Program and UCSF Parnassus clinic. Services coordinated with South Van Ness Adult Behavioral Health Services to avoid duplication

# Women's CoE - Demographics



# Women's CoE

- Treatment Adherence challenges: histories of trauma, homelessness, mental health and substance use issues, often with additional co-morbidities of hepatitis and diabetes
- Executive Committee meets monthly
- CAB for WCOE is funded through RWPD and oversees all Ryan White funded programs

# Women's CoE

- Coordinated Electronic Medical Records charting by WCOE staff
- Comprehensive primary medical care, incl. OB/GYN care with wrap around case management/support services
- Linkages to medical, housing, legal, financial, mental health, and substance abuse treatment services mostly for adult women not currently with children
- Trauma informed care in sync with DPH Initiative

# Women's Clinic Team





# Potential Impact to CoE's as Ryan White Eligible Clients Become ACA Enrollees or Part of Expanded Medicaid

ACA Services may include:	Enrollee may become ineligible for these RW Core Service Categories:	Enrollee: Remains eligible for these RW Service Categories:
<ul style="list-style-type: none"> <li>❖ Ambulance Services</li> <li>❖ Diagnostic &amp; Laboratory</li> <li>❖ Durable Medical Equipment</li> <li>❖ Emergency &amp; Post-stabilization</li> <li>❖ Family Planning</li> <li>❖ Home Health Care</li> <li>❖ Mental Health (Outpatient &amp; Acute Inpatient)</li> <li>❖ Non-emergency Medical Transportation</li> <li>❖ Outpatient Alcohol &amp; Drug Treatment</li> <li>❖ Podiatry</li> <li>❖ Prescriptions (Inc. ADAP/HIV Medications – ADAP Disenrollment Required)</li> <li>❖ Preventative &amp; Primary Care Services</li> <li>❖ Radiology</li> <li>❖ Short-term Rehabilitation</li> <li>❖ Specialty Care</li> <li>❖ Therapy (Occupational, Physical, Speech)</li> <li>❖ Urgent Care</li> </ul>	<ul style="list-style-type: none"> <li>❖ OUTPATIENT/AMBULATORY MEDICAL CARE</li> <li>❖ HOME HEALTH CARE</li> <li>❖ MEDICAL CASE MANAGEMENT (INCLUDING TREATMENT ADHERENCE)*</li> <li>❖ OUTPATIENT MENTAL HEALTH SERVICES*</li> <li>❖ OUTPATIENT SUBSTANCE USE SERVICES*</li> </ul> <p>*LEVEL OF SERVICE PROVISION AND FREQUENCY TO BE DETERMINED BY STATE OF CALIFORNIA</p>	<p><b>RYAN WHITE CORE SERVICES:</b></p> <ul style="list-style-type: none"> <li>❖ ORAL HEALTH CARE (DENTAL)**</li> <li>❖ FACILITY-BASED CARE (NOT ACUTE HOSPITAL CARE)</li> <li>❖ HOSPICE</li> </ul> <p><b>RYAN WHITE SUPPORT SERVICES:</b></p> <ul style="list-style-type: none"> <li>❖ HOUSING SERVICES</li> <li>❖ FOOD BANK/DELIVERED MEALS</li> <li>❖ PSYCHOSOCIAL SERVICES</li> <li>❖ LEGAL SERVICES</li> <li>❖ NON-MEDICAL CASE MANAGEMENT (BENEFITS COUNSELING &amp; MONEY MANAGEMENT)</li> <li>❖ OUTREACH SERVICES</li> <li>❖ EMERGENCY FINANCIAL ASSISTANCE</li> <li>❖ RESIDENTIAL SUBSTANCE USE SERVICES</li> </ul> <p>**ORAL HEALTH CARE MAY BE REINSTATED AS COVERED SERVICE WITH LEVEL &amp; FREQUENCY TO BE DETERMINED BY STATE OF CALIFORNIA</p>



# Post ACA Implementation populations that will continue to receive medical services through Ryan White Funding

- Residually ineligible individuals (undocumented and those documented with resident status < five years)
- Patients with significant behavioral health issues
  - At high risk for falling out of care
  - Often are 86-ed out of multiple programs
  - At higher risk for depression, chaotic substance use, violence and suicide than general population
  - Have limited insight to modify behavior
  - Don't meet criteria for "mental disability"
  - DSM5 Axis II "Personality Disorder" fixed traits or diagnosis
    - Important to move beyond labels to see what is needed both for patient and system
      - » Borderline is often over diagnosed and underdiagnosed
      - » Often described as "low threshold patients"
- Clients who are eligible for, but opt out of enrollment of Covered California. HRSA requires "Vigorous Pursuit" of clients who make this decision

# Post ACA Implementation populations that will continue to receive medical services through Ryan White Funding (continued):

- Clients who are eligible for but choose not to enroll in Covered California may still be eligible for Healthy San Francisco until January 2016 (perhaps longer)
- “Vigorous Pursuit” will need to be documented and retained by service providers

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