

Strut 2017-2018 Summary of Findings

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Learning for Action



Learning for Action enhances the impact and sustainability of social sector organizations through highly customized research, strategy development, and evaluation services.

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I. Introduction

Evaluation Purpose

The San Francisco AIDS Foundation (SFAF) engaged Learning for Action (LFA) in 2014 to design and later implement an evaluation of the integrated service model at Strut. Strut's stated mission is to promote the health and wellness of gay, bi, and trans men, to strengthen diverse communities, and to reduce the impact of HIV in San Francisco. In recent years, this mission has evolved to be more inclusive of the diverse local community that may wish to seek services at Strut, including women-identified participants¹ and sexual partners of gay, bi, and trans men. The Strut model is designed to combine community engagement with biomedical and behavioral services to create a synergy that will lead to improved health outcomes beyond those achieved by each service individually. **Specifically, within five years of integration, the Strut model aims to see: a reduction in new HIV infections by 40%; a reduction in community viral load; a reduction in substance use-related HIV transmission risk; an increase in resiliency among GBT men; and an increase in community connectedness.** To assess progress toward these goals, Strut is tracking a variety of outcomes, including (but not limited to): risk reduction strategies for HIV/STI transmission (including PrEP use); STI diagnosis; length of time since completing an HIV test (for HIV-negative individuals); engagement in medical care (for HIV positive individuals); length of time since most recent medical visit (for HIV-positive individuals); social supports; and substance use. Strut has demonstrated remarkable progress on several key outcomes, as described further in this report. Of note, PrEP use among HIV-negative respondents has almost doubled since 2015, from 27% to 46%; nearly all (89%) HIV-positive respondents report being virally suppressed, a statistically significant increase from 2015 (81%) ; and three-fourths of HIV-positive respondents report having a medical visit within the past three months, an increase from 2015 (64%). There are a few areas in which Strut has faced greater challenges in reaching the model's goals. Specifically, STI diagnosis rates have increased in the community, as PrEP has been accompanied by greater frequency of STI testing and, in some cases, reduction of sexual protection practices. In addition, resilience and social support measures suggest that Strut participants have additional needs for supports to enhance resiliency and social connectedness.

An overriding goal of the Strut model, through the integration of SFAF programs, is to contribute to key outcomes to a greater degree than the existing SFAF programs could do on their own, operating independently. For a number of reasons, program integration has taken place more slowly than anticipated, and Strut will have more information about the success of the integrated model in time. The transition to new leadership, delays in facilitating relationships across program staff, and an extended timeline for rolling out the Electronic Health Record system across all programs contributed to a slower launch period for program integration.

This report provides SFAF with findings about Strut participant demographics, health behaviors, and health outcomes in 2018, approximately two years after Strut opened its doors. It includes comparisons of findings from 2015 (prior to when the integrated service model launched) and 2018 for a subset of outcomes that SFAF has identified as high priority for monitoring over time. This third year of the evaluation also places the outcomes and changes in those outcomes over time in context with those in the larger San Francisco HIV landscape by drawing on findings from the National Health Behavior Surveillance Survey (NHBS). In addition, the report describes successes and opportunities in Strut's

¹ According to staff, the increase in women participants is particularly notable at mobilization events, such as art openings, though measures of event participation are not included in this report.

implementation and progress toward its intended outcomes since it opened from the perspective of staff, participants, and external stakeholders.

Methods

This evaluation draws on five data sources: 1) Core Variables and Essential Questions (CVEQ) form and Electronic Health Record (EHR) system records; 2) National Health Behavior Surveillance survey; 3) Strut staff interviews; 4) Strut participant focus groups; and 5) External stakeholder interviews. Methodology for each of these sources is described below.

Participant Core Variables and Essential Questions (CVEQ)

Instrument and Data Collection

SFAF provided LFA with participant demographic, health behavior, and health outcome data from the seven programs operating as part of Strut. Programs collect data using the CVEQ form and Electronic Health Record (EHR) system records. At the time of data collection, Magnet, Positive Force, DREAM, 50 Plus, and Health Navigation were using the integrated Electronic Health Record (EHR) system to collect CVEQ data; Bridgemen and Stonewall were not yet integrated into the EHR system and data were collected using paper forms. Participant CVEQ data included in this report were collected primarily between February and April 2018. When a participant did not have recent data available for a given variable, their responses from an earlier point in time were used, up to three months in the past.²

The seven programs' data collection instruments included similar questions, but there are discernable differences among the instruments for a subset of the questions. While the instruments have largely remained consistent over time, some changes have resulted in variation in the data between 2015 and 2018.³ This is particularly true for the revised instrument Magnet used in 2017 when the program adopted the EHR, which does not include several questions that Magnet collected in previous years and that other Strut programs continue to collect.⁴ In order to ensure that Magnet data are comparable to the other programs, a supplemental form was administered to 293 Magnet participants in March 2018.

To assess the contributions of the Health Navigation program in connecting HIV-positive participants to medical care and other supports, SFAF also provided referral and linkage data for participants in the program between January and March 2018. These data are included in the report. Because Health Navigation was newly launching when Strut opened, data from 2015 are not available.

Sample Size

As in prior years, LFA recommended that SFAF provide the largest sample of cases from Magnet, which represents the majority of the program participants at Strut, and a minimum of 50 cases from the

² Demographic data available from any point in time were used when available.

³ In 2015, SFAF identified the Bridgemen instrument as the standard by which LFA would determine which CVEQ variables to include in the analysis and how to aggregate responses across programs. For many of the variables in the Bridgemen instrument, identical corresponding questions are included on the other programs' survey instruments. For other variables, slightly different questions are similar enough to be aggregated with the Bridgemen format. However, several variables in the Bridgemen instrument do not have comparable counterparts in other programs' instruments, and thus some programs are not incorporated into the aggregate sample for certain variables.

⁴ SFAF intentionally minimized the number of questions asked of Magnet participants when it adopted the EHR in order to reduce the burden on staff and participants; in addition, some information from the CVEQ was already being collected from a subsample of Magnet participants at regular intervals.

remaining programs in order to increase the likelihood that the samples are representative of the diversity of participants in each program. SFAF provided 50 cases per program when possible, but some programs did not have this amount of data available.

As seen in Exhibit 1, the total number of participants served by each program varies widely. In order to ensure that the findings reflect the composition of the aggregate program participants, the data are weighted according to the size of the corresponding program. Accordingly, the sample sizes reported throughout this report represent the weighted sample sizes, with the exception of Exhibit 1, which shows the true sample sizes from each program. In Exhibit 1 and throughout the report, data collected between April 2014 and July 2015 (before program integration), are presented for comparison purposes. These pre-program integration data are labeled as “2015” in this report.

Exhibit 1. Sample Size by Program

Program Name	Approximate Program Size		Sample Size (n)		Percent of Sample	
	2015	2018	2015	2018	2015	2018
Total	8,600	10,740	475	1,342	100%	100%
Magnet	7,000	8,300	198	1,030	42%	77%
Positive Force	150	250	75	75	16%	6%
Bridgemen	400	500	64	41	13%	3%
DREAAM	50	90	55	35	12%	3%
Stonewall	700	900	49	21	10%	2%
50-Plus	300	375	34	118	7%	9%
Health Navigation	N/A	325	N/A	22	N/A	2%

Note: Percentages may not sum to 100% due to rounding.

Program sizes for Magnet are slightly different than the estimates used to calculate the weighted sample sizes for analysis. The differences are minor and would yield very similar results.

A review of respondents’ Confidential Participant Labels (unique identifiers) revealed that 120 cases in the sample were duplicates (i.e. cases in which a single individual had completed a CVEQ multiple times, either at multiple points in time for a single program or for different programs). In these instances, LFA retained the most recent cases in the data file; when the data collection periods of the duplicates were identical, LFA retained the case with the most complete set of data. Among the 120 duplicate cases that were removed, 105 were from Magnet, eight were from 50 Plus, and seven were from Positive Force. Once the duplicate cases were removed, there were a total of 1,342 cases remaining in the dataset.

Data Analysis

LFA conducted quantitative data management and analysis procedures using the Statistical Package for the Social Sciences (SPSS). LFA ran frequencies and descriptive statistics of the 2018 data. In addition, LFA conducted statistical analyses to explore the differences between the 2015 and 2018 data and to identify any differences in health behaviors and outcomes by key independent variables, such as race/ethnicity and age.

For analyses that examined health behaviors and outcomes, the samples from both time periods were restricted to participants who had been involved in Strut programming for three months or longer when they completed the questionnaire in order to limit the analysis to participants who have been involved in

Strut programming for enough time to experience contributions of Strut programs to their health behaviors and outcomes. Throughout the report, footnotes are included to identify when the data are limited to this sub-sample of participants.

National Health Behavior Surveillance (NHBS) Survey

When SFAF and LFA designed the Strut evaluation in 2014, they identified the National HIV Behavior Surveillance (NHBS) Survey data as a possible comparison group that would allow SFAF to assess changes in health outcomes and behaviors over time for its participants relative to changes in health outcomes and behaviors over time for a population with similar characteristics but that did not access Strut programs and services. The NHBS survey, released by the Centers for Disease Control and Prevention (CDC), is a standardized survey that provides population-based estimates of behavioral indicators among men who have sex with men (MSM) every three years.⁵ In 2015, LFA compared NHBS data collected from 411 respondents in San Francisco in 2014 with SFAF participant data collected prior to the opening of the integrated service model at Strut in order to determine if the NHBS data reflected a population similar enough to the Strut client population to serve as a comparison group. The analysis revealed that while the populations were not identical along all characteristics of interest, they were sufficiently comparable to serve the comparison group role. The 2014 data are used for a pre-Strut comparison and the 2017 NHBS data (the subsequent time of NHBS Survey implementation) are used as a comparison group for the Strut data collected in 2018.⁶ Throughout the report, when NHBS data are referenced as a comparison to the Strut data, the data collection periods are referred to as “Time 1” (2014) and “Time 2” (2017). This convention is used to minimize confusion about the data collection time periods, which are slightly different for NHBS and Strut.

The 2017 NHBS survey included a question about participation in Strut programming. Nearly one third (32%) of NHBS respondents reported that they had accessed any Strut services (HIV/STI testing or other programming). Specifically, 27% had accessed HIV/STI testing services and 13% had accessed other programs and services aside from testing. Assuming the NHBS survey respondents are representative of the MSM population in San Francisco, then these findings could be used to approximate Strut’s reach. In order to ensure that the 2017 NHBS sample is a distinct comparison group, respondents who reported that they had participated in any Strut programming (testing or other programs and services) were removed from the 2017 NHBS comparison group sample.⁷

Data Analysis

LFA ran frequencies and descriptive statistics of the 2017 NHBS data and conducted statistical analyses to explore the differences between the 2014 and 2017 NHBS data.

Before conducting statistical analyses to explore differences between the NHBS and Strut samples, LFA used a technique called *propensity score matching* (PSM). PSM, at its best, allows one to use a well-matched comparison group to *approximate a true control group*, and then compare results for the matched comparison group with the participant group to *estimate* what would have happened if participants had *not* accessed Strut’s programs and services. While the comparison is indeed helpful, the

⁵ Kellogg et. al. (2013). Comparison of HIV Behavioral Indicators Among Men Who Have Sex With Men Across Two Survey Methodologies, San Francisco, 2004 and 2008. *Sexually Transmitted Diseases*, 40 (9), 689-694.

⁶ The data collection time periods for NHBS and Strut are not perfectly aligned, but they are relatively close. NHBS data were collected from July-December 2014 and from August-December 2017, and Strut data were collected between April 2014 and July 2015 (Time 1) and February-April 2018 (Time 2).

⁷ The 2014 NHBS survey did not include a question about Strut participation, and thus participants in SFAF programs that later became part of Strut could not be identified and removed.

data available for this analysis have several limitations, which are included in the Limitations section below.

After creating the matched samples, LFA conducted statistical analyses to compare differences between samples, including Analysis of Covariance (ANCOVA) to statistically control for the effects of key variables where there were differences between the NHBS and Strut samples.

Finally, in order to assess how the health behaviors and outcomes among Strut participants compare to those among the broader San Francisco MSM population *and* to assess if the changes observed in the Strut client population between pre- and post- program implementation are reflective of similar population-wide trends, LFA compared the results of the 2014 and 2017 NHBS analyses with the 2015 and 2018 Strut analyses. These analyses facilitated assessing possible contributions of the Strut model to participants' health behaviors and outcomes.

Considerations for Interpreting Findings

There are some contextual factors to understand when reviewing and interpreting participant data. These are described below.

- **Changes in the HIV prevention and treatment landscape:** In recent years, more widespread access to prevention and treatment options and increased awareness about these options have played a critical role in influencing the behaviors and health outcomes of people at risk of contracting or transmitting HIV. The u=u (undetectable=untransmittable) campaign has spread the message that when HIV-positive individuals have effective treatment, reducing their viral load to undetectable, this protects their health *and* means that they will not transmit HIV to sexual partners.⁸ Another pivotal change in the field is increased awareness of and access to PrEP. PrEP (Pre-Exposure Prophylaxis) is an anti-HIV medication that helps to prevent HIV-negative people from becoming infected. Since the Centers for Disease Control and Prevention (CDC) released guidelines recommending daily use of PrEP for high-risk individuals in 2014⁹, access to and use of PrEP has increased throughout the U.S. In accordance with this trend, Strut participants have been accessing PrEP in much greater numbers. This has contributed to an increased volume of participants who access Magnet services, especially due to the CDC and Strut's requirement for PrEP clients to receive an HIV test every three months. Increased PrEP use may affect some of the findings in the report, including frequency of HIV testing and also certain sexual risk indicators, which may be higher than in previous years because some participants may rely on PrEP alone for HIV prevention.¹⁰
- **Program services locations:** While the programs included in this evaluation are considered part of the Strut model and operate at least in part within the Castro location, not all programs operate exclusively within the Strut building. Bridgemen is based out of Strut, but many events are held offsite in the community. Health Navigation is also based at 1035 Market, but services are offered at Strut as well. 50-Plus holds many large group events at 1035 Market or at outside locations. Stonewall provides services at 1035 Market and at Strut. The evaluation seeks to assess changes in participant use and outcomes across all programs in the model because of the model's role in better facilitating collaboration and connections across programs, regardless of the specific location of all activities and events.

⁸ For more information about u=u, see <https://www.preventionaccess.org/about>

⁹ "HIV PrEP Guidelines." Released May 14, 2014. Centers for Disease Control and Prevention. Available at <https://www.cdc.gov/nchhstp/newsroom/2014/PrEP-Guidelines-Press-Release.html>

¹⁰ PrEP does not prevent the transmission of other diseases, and Strut staff have echoed a concern shared in the healthcare field that PrEP use may lead to reduced use of safe sexual practices, such as condom use.

Interviews and Focus Groups

Data Collection

In order to learn more about the successes, challenges, and opportunities associated with the integrated program model at Strut, LFA staff conducted interviews with 10 Strut staff and five community stakeholders, and facilitated three focus groups with a total of 21 participants who access services and/or participate in programs.¹¹ The staff members interviewed included program managers, directors, and front line staff representing each of the programs operating at Strut. The community stakeholders interviewed represented organizations in San Francisco that provide HIV and STI prevention and treatment services, provide other social services to the LGBTQ community, or are members of the local business community in the Castro. Focus group participants represented a diversity of backgrounds and identities, including a range of race/ethnicity groups, ages, and experience with a variety of programs. Magnet, PrEP, and Stonewall were the most heavily represented programs.

Data Analysis

LFA staff used an inductive coding process to analyze the data collected from interviews and focus groups in order to identify prominent themes and unique insights.

Strengths and Limitations

The following section describes strengths and limitations of the data presented in this report.

Strengths

- **Diverse respondent pool:** The data include participants from all seven programs who represent a diversity of ages, racial groups, and sexual orientations. Staff interview participants represent the seven programs and also come from a diversity of roles, ranging from direct service providers to SFAF leadership. Focus group participants represent the seven programs and are diverse in their demographics and length of time using Strut services (ranging from a few months to many years). External stakeholder interview participants represent a range of organizations, including two focused on HIV and STI treatment and prevention, one providing other services to the LGBTQ community, one serving the Castro community, and a policymaker.
- **Robust sample size:** With 1,342 cases, including cases from all seven programs, the sample includes a sufficiently high number of responses to have confidence that it is adequately representative of the participant population and to allow for statistical testing. The number of participants involved in external stakeholder interviews (5), staff interviews (10), and focus groups (21) contributes to a diverse and nuanced set of findings.
- **Sample reflects program population:** Because the data are weighted according to program size, the data reflect the overall composition of the clients served by the SFAF programs. Staff interview and focus group participants were selected to represent all seven programs, though the number from each program does not exactly reflect the relative size of the programs.
- **Comparisons to pre-integration data:** For most of the variables collected in 2018, comparable data are available from 2015, before the integrated model was launched. Similarly, LFA has conducted staff interviews and participant focus groups annually since 2016, which allows for analysis of cross-year themes and changes over time.

¹¹ Staff interviews were conducted in April 2018, client focus groups were conducted in May 2018, and external stakeholder interviews were conducted in June 2018.

- **Comparisons to a well-matched comparison group:** For many key variables collected among Strut programs, comparable data are available from the NHBS dataset. LFA used propensity score matching to create a well-matched comparison group that allows for comparisons between the Strut and NHBS samples.

Limitations

- **Service-seeking participant sample:** Because of the nature of the programs and services that Strut, as a health care provider, offers, participants are more likely than the general population to access health care services, such as accessing HIV and STI testing and treatment and mental health services. Thus, rates of service access may be inherently higher among Strut participants than among the NHBS comparison group.
- **Incongruous data collection instruments:** The CVEQ instrument used by each program differs from program to program and between the two time periods in a number of ways. This is especially true for the EHR data system used by Magnet, which does not include some key variables in the other program instruments. (This year, as noted, some of these variables were collected from a subset of Magnet participants.) Often, questions on the various instruments are worded differently, offer different multiple choice responses, or are missing from one or more instruments. This means that for some variables, the denominator is markedly lower than the total number of cases in the full Strut sample. This means that for select variables the results are not representative of clients from all programs.
- **Limited comparisons to the matched comparison group:** Comparisons to NHBS data could only be made for the subset of Strut variables that were also included in the NHBS survey. While NHBS data were available for many key variables, some are missing, including sexual risk (e.g. condom use) and mental health measures.
- **Potential overlap in pre-integration samples:** Because the NHBS survey did not include a question about participation in SFAF programs (which later became part of Strut) in 2014, this sample may include some people who accessed SFAF programs and services before the Strut integration.
- **Self-selected sample of focus group participants:** While Strut staff successfully recruited a diverse group of participants to take part in the focus groups, participants who elected to participate in the groups may not fully reflect and represent the Strut population. For example, focus group participants may be more likely than those who did not participate in focus groups to have accessed services recently and to be highly involved in Strut programming. Hence, the focus group findings may not represent the perspectives of participants who access services relatively infrequently, for example, people who visit the clinic every few months for testing but are not involved in other programming.
- **Limitations in assessing program integration:** While an overarching goal of the integrated model is to support staff and participants to make connections and referrals across programs, there are limited data available to describe rates of integration over time. SFAF has 2018 data available that describe the rates of cross-program usage among clients in community engagement programs (DREAAM, Bridgeman, and 50-Plus). However, similar data are not available from 2015. Interviews with staff and focus groups with participants provide some information about the extent of integration, and program surveys gather information about any additional programs participants access, but these data are not comprehensive enough to assess progress toward integration goals. Additional quantitative data about participant referrals, connections with services, and cross-program use will be available once all programs collect data using the EHR system, which will facilitate analysis of the effectiveness of Strut's cross-program referral and connection efforts.
- **Limitations to the comparison group and to the propensity score matching model (PSM):** While the LFA team used propensity score matching to make the groups as comparable possible, there are several limitations to the strength of the NHBS sample as a comparison group for the Strut sample. A

limited set of variables was available for use in developing the comparison groups. LFA used race/ethnicity and age to construct the groups. Additional variables that would have been helpful to use, but were not available, include socio-economic status and education level. After the matching process was completed, some of the Strut programs were not represented in the PSM sample. Health Navigation was not included at Time 1 or Time 2, and Stonewall was not included at Time 2. Magnet and Bridgemen were most heavily represented. At Time 2, Magnet accounts for 82% of the sample, and Bridgemen accounts for 10% of the sample. Thus, the PSM sample does not fully reflect the diverse range of program participants. For example, Stonewall participants (who are not represented at Time 2), may be more likely than other program participants to use substances and have mental health needs. Additionally, the NHBS sample only includes people who live in San Francisco, while Strut participants include people from surrounding communities as well. Health behaviors and outcomes may be different for San Francisco residents compared to those in other areas; perhaps most notably, HIV rates tend to be lower in San Francisco compared to other communities.

II. Participant Demographics, Health Behaviors, and Health Outcomes Key Findings

This section describes the findings from the 2018 evaluation. These findings include: Strut participant demographics; health behaviors and outcomes in the areas of sexual health, substance use, mental health, and social support; internal Strut operations and cross-program collaboration; and community partnerships and Strut’s role in San Francisco’s HIV prevention and treatment landscape.

Client Demographics

Since Strut opened, the population of participants and staff has become **increasingly racially/ethnically diverse**. Specifically, there has been an increase in the percentage of Latino, Asian, and African American participants. There have also be small increases in women and trans* participants, although the number of those participants remain very small. With the rise of PrEP, Strut has also experienced an increase in the number of uninsured and undocumented participants, according to one staff member.

Race/Ethnicity

Compared to 2015, there is a **significantly greater percentage of participants that identify with a race/ethnicity group other than Non-Hispanic White**

($p < .001$). The majority (53%) of respondents identify as Non-Hispanic White, followed by Latino (21%), Asian (13%), and African American (6%).

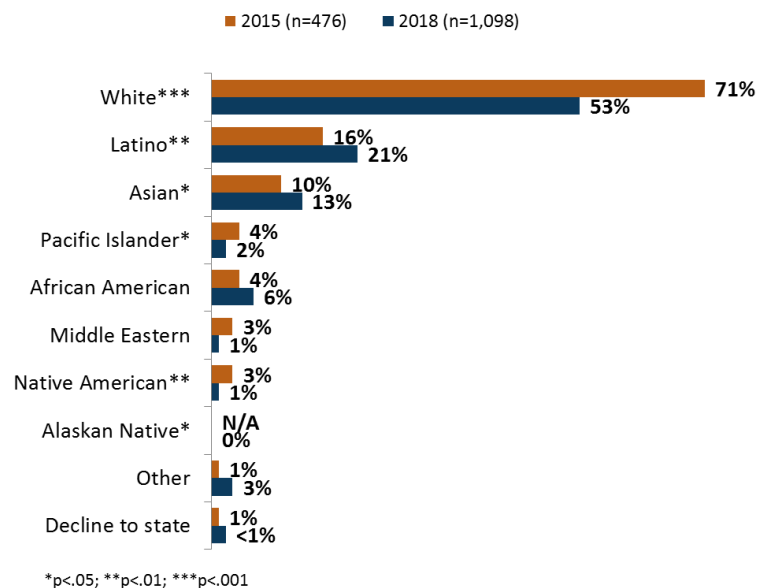
Many respondents identify with multiple racial/ethnic groups.

The racial/ethnic

composition of the Strut sample is somewhat different from the NHBS sample. Compared to the Strut sample, a greater majority of NHBS respondents identify as White (80%), African American (9%), and Native American (8%). A similar percentage identify as Latino (24%), and slightly smaller proportion identify as Asian (9%).

As in the past, staff and participants continue to call for Strut to serve and nurture a **more racially diverse community**, specifically by increasing the racial diversity of staff and increasing the number of Spanish-speaking staff.

Exhibit 2. Race and Ethnicity



* $p < .05$; ** $p < .01$; *** $p < .001$

Note: “Alaskan Native” was not a response option on the 2015 survey and was not a response option for some programs in 2017.

Note: Percentages do not sum to 100% because respondents were asked to select all responses that apply.

Exhibit 3. Age

Age Range in Years	Percent of Respondents	
	2015	2018
20 and under	2%	1%
21-30	33%	29%
31-40	30%	28%
41-50	18%	19%
51-60	12%	15%
61-70	5%	6%
71 and older	0%	2%

2015: n=472; 2018: n=1,213

Note: Percentages do not sum to 100% due to rounding.

Age

More than half (57%) of participants are between the ages of 21 and 40, which is slightly lower than in 2015 (63%). The overall distribution of respondents across the age groups is markedly similar at both points in time (Exhibit 3). The average age is just slightly higher in 2018 (39.4 years) compared to 2015 (37.6 years) ($p < .01$). In 2018, the NHBS sample trends slightly older, with 32% over the age of 50, compared to 23% in the Strut sample.

Sexual Orientation

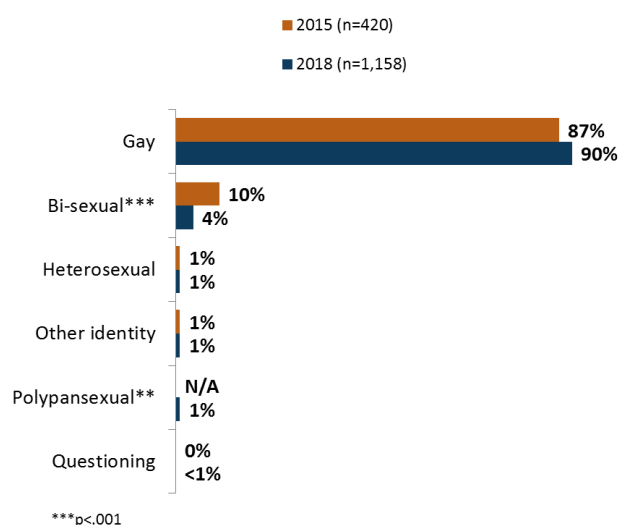
Similar to 2015, a large majority (90%) of respondents identify as gay, followed by a much smaller percentage (4%) identifying as bisexual. There are a relatively smaller percentage of bisexual respondents, compared to 2015 (Exhibit 4).

Gender

Almost all respondents (99%) identify as male, which is similar to 2015 (97%). A very small percentage of respondents identify as female (2%), transgender (1%), and genderqueer (<1%).

Likewise, almost all respondents (98%) report that the sex on their birth certificate is male, which is similar to 2015 (99%).

Exhibit 4. Sexual Orientation



Note: Response options were coded as separate variables in order to accommodate differences in instruments across programs. Given the response option differences, percentages do not sum to 100%.

As the total number of new HIV cases continues to drop, and at a higher rate among MSM than other populations, SFAF is mindful of the importance of the need for increased accessibility to services in San Francisco for populations who may have higher needs for HIV prevention and treatment services, including trans* people and women. How they contribute to this, however, may include support for partners in the community, increased direct services for those populations through other SFAF sites, and not necessarily through intentional shifts in target populations at Strut. Strut is not actively reaching out to trans females and cis-women, and while the number of those participants remains small,¹² **Strut staff have actively worked to increase their competency and comfort with serving these populations to ensure that those who do seek services at Strut receive high quality care.** Strut has acquired medical

¹² Strut staff noted that a greater number of trans and women clients may be served at other SFAF sites.

equipment needed to serve trans* and women, and trains clinic staff to prepare them to best meet women and trans* participants' medical needs and to provide culturally competent support. Strut has also hired a more diverse staff to better reflect the participants they serve. Staff have observed that more women, including some cis women, are seeking care at Strut because of the non-judgmental and client-centered care available to them. Participants and staff indicated that there is still progress to be made for Strut staff to become more skilled and comfortable in their ability to provide services to women and trans* participants.

Additionally, two external stakeholders spoke to the importance of Strut considering its role in serving women and trans* community members within the context of the full community of health and wellness providers in San Francisco that serve the LGBTQ community. They explain that, for example, many trans* people may not feel safe in the Castro, and thus may be better served by another provider in the city. It is important that Strut be equipped to serve a diverse population *and* to think about their services as one part of a larger network of community services available. As Strut continues to define its role as a provider and refines the populations it seeks to serve, leadership have an opportunity to engage thoughtfully with community partners and identify how they can complement each other's services.

Geographic Location

A larger percentage of Strut participants live outside of San Francisco, compared to 2015 (22%, compared to 15% in 2015; $p < .01$). This trend may reflect the increasing cost of housing in San Francisco, which has pushed many former residents to live elsewhere, and an increase in visibility of Strut as a leader in sexual health services – and PrEP services in particular – which may be driving an increase in out-of-city participants. Among participants who are San Francisco residents, the geographic locations where they live are largely the same as they were in 2015. Though not statistically significant, there is a smaller percentage of participants living in the Castro (18% compared to 22% in 2015) (Exhibit 5).

Exhibit 5. Zip Code of Residence

Zip Code	Percent of respondents	
	2015	2018
94114 (includes the Castro)	22%	18%
94110 (Mission and Bernal Heights)	9%	9%
94102 (Hayes Valley and part of Tenderloin)	6%	5%
94117 (Haight-Ashbury)	5%	6%
94109 (Russian Hill and part of Tenderloin)	6%	4%
94103 (part of SOMA and upper Mission)	5%	6%
94131 (Glen Park)	5%	3%
94112 (Balboa Park, Outer Mission, Oceanview, and Excelsior)	3%	3%
94116 (Sunset, (Inner) Parkside, Forest Hill, and West Portal)	1%	2%
Outside of San Francisco**	15%	22%

2015: n = 426 and 2018: n=1,176

** $p < .01$

Sexual Health

Strut is a leader in sexual health care, specifically in providing the LGBTQ community with the latest available options for HIV and STI prevention and treatment in a caring, non-judgmental way. Overall, **participants express satisfaction with the high quality of client-centered programs and services offered by Strut staff**, which, for many people, is different from the quality of care they experience with other traditional medical providers. External stakeholders see Strut playing a critical role in serving participants who often have not felt comfortable with providers in other clinical settings.

Strut has continued to innovate and adapt systems to increase access to quality care each year. In particular, leadership has created new systems to increase availability of appointments, reduce wait times, and increase client comfort. In 2017, Magnet implemented Magnet Express, which allows returning clients without symptoms to access HIV and STI testing in an expedient walk-in appointment. Many PrEP clients use Magnet Express for their regular three-month testing appointment. Magnet Express has bolstered the number of clients that access clinic appointments by approximately 300 appointments per month. Another important change to increase client comfort relates to the same-day appointment system: In response to feedback Strut received about the discomfort and shame some participants felt while waiting outside the building in the morning same-day appointment line, Strut implemented a new system through which participants simply take a number in front of Strut in the morning and return upon the building's opening to get their appointment slot. Finally, Strut has also begun to offer Hepatitis C treatment and introduced a bridge program to help participants access anti-retrovirals (ARV's) during a transition in insurance plans.

PrEP Use

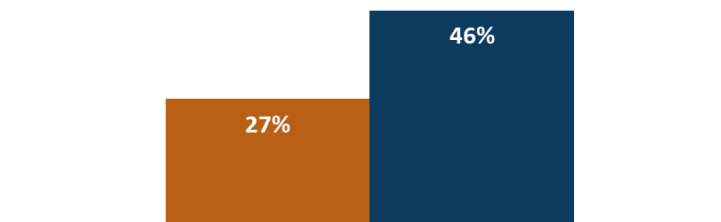
SFAF is a leader in the HIV prevention and care field, and Strut in particular is playing a significant role in increasing access to PrEP.

Among other strategies, increased use of PrEP is a critical tool in the Getting to Zero SF campaign, which has a mission of achieving zero new HIV infections, zero HIV deaths, and zero HIV stigma by 2020.¹⁴

The percentage of HIV-negative Strut respondents that report taking PrEP has almost doubled since 2015, from 27% to 46% (Exhibit 6). By comparison, PrEP use among NHBS respondents began much lower than among the Strut participants (11%) and quadrupled by 2018 (44%). While this brings the rate of PrEP use to comparable levels when looking at the full Strut sample, when we compare to the propensity score matched sample (which is the sample designed to better match that of the NHBS sample), the rate of use among Strut participants is nearly 10 percentage points higher, suggesting higher PrEP use among Strut participants than among the

Exhibit 6. PrEP Use in Previous 12 Months¹³

■ 2015 (n=258) ■ 2018 (n=541)



¹³ For both years, this variable is reported only for respondents who had been accessing services for at least three months. 2015 data were obtained through a select-all-that-apply question which asked participants to indicate the strategies they used to protect themselves and their partners during sexual activity. 2018 data were obtained through a question that specifically asked participants whether or not they had used PrEP in the previous 12 months.

¹⁴ <http://www.gettingtozerosf.org/>

broader San Francisco MSM population. The changes seen among both groups reflect a national trend of increasing access to and use of PrEP, which has been recommended by the Centers for Disease Control and Prevention (CDC) as an HIV-prevention strategy for high-risk individuals. However, nationally, PrEP use among gay and bisexual men is much lower, compared to both the Strut and NHBS samples. A national study conducted between March 2016 and March 2017 found the usage rate to be 4.1%.¹⁵

STI Diagnosis

In recent years, STI rates in San Francisco have been on the rise. This can be explained partly by an increase in testing, which reveals infections that went undiagnosed in the past. In addition, as PrEP plays an increasingly prominent role in the HIV prevention landscape and users' fear of HIV transmission decreases, participants may be less likely to engage in behaviors that prevent STI transmission. Staff and participants explained that increased PrEP use has been correlated with an overall decrease in risk reduction strategies such as condom use.

While Strut staff actively encourage STI testing and treatment strategies – including three-site STI testing, condom provision, and use of partner packs, external stakeholders and participants identified an **opportunity for Strut to promote and encourage STI prevention with the same level of urgency as they treat PrEP access.** External stakeholders also invite Strut, as a leader in the landscape of STI and HIV prevention and treatment, to communicate broadly to the community and the City the utmost importance of preventing STI transmission. This message is critical to “getting to zero” with STI’s, as well as with HIV, and to securing needed funding for these public health initiatives.

In 2018, **45% of Strut respondents reported being diagnosed with an STI.**¹⁶ By comparison, 31% of NHBS respondents reported STI diagnosis, an increase from 20% in 2015 ($p < .001$).¹⁷ While 2015 data are not available for Strut, the increase in STI diagnosis among the NHBS sample suggests that increased PrEP use may be correlated with increased STI diagnosis at this point in time.

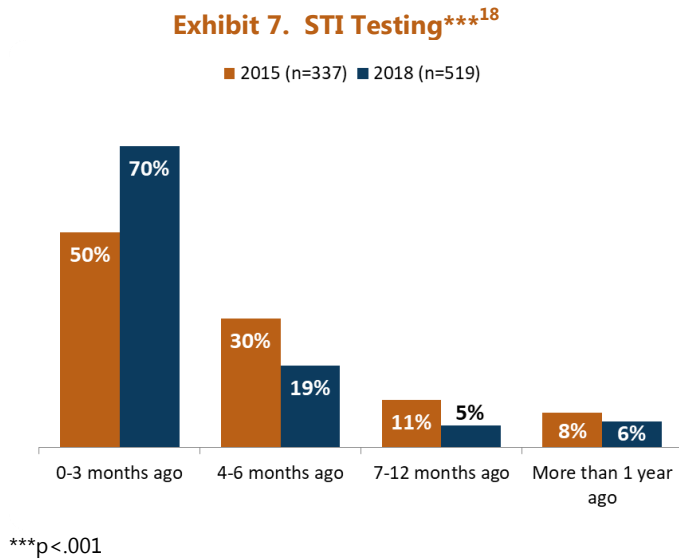
¹⁵ Hammack PL, Meyer IH, Krueger EA, Lightfoot M, Frost DM (2018) HIV testing and pre-exposure prophylaxis (PrEP) use, familiarity, and attitudes among gay and bisexual men in the United States: A national probability sample of three birth cohorts. PLoS ONE 13(9): e0202806. <https://doi.org/10.1371/journal.pone.0202806>

¹⁶ Magnet data are not available for 2015, so this variable is not reported here.

¹⁷ Given that many Strut participants visit Strut specifically to access medical services, it is unsurprising that respondents report a higher rate of STI diagnosis compared to the NHBS sample in 2018.

STI Testing

As part of efforts to reduce STI transmission, Strut continues to encourage participants to engage in regular STI testing, ideally every three months. **Testing rates have risen, with 70% of all respondents reporting having a STI test within the past three months, compared to 50% in 2015** (Exhibit 7). The percentage of Black and Latino participants was notably higher than that of White participants in 2018 (80% and 81%, compared to 68%). This difference may be reflective of Strut's concerted efforts to draw in more people of color for services, including through strengthened partnerships between events with BBE and DREAAM and testing services.



***p<.001

STI testing rates among Strut participants remain higher than the NHBS comparison group. Looking at testing within the previous 12 months, the testing rate among Strut participants was markedly higher than among the NHBS respondents at Time 1 (94% compared to 65%). The rate among Strut participants has stayed approximately the same (92% in 2018), while the rate has increased by nearly 10 percentage points among the NHBS respondents. Given that Strut had a high testing rate already in 2015, it is not surprising that it has not increased, while testing has increased among the larger San Francisco MSM population.

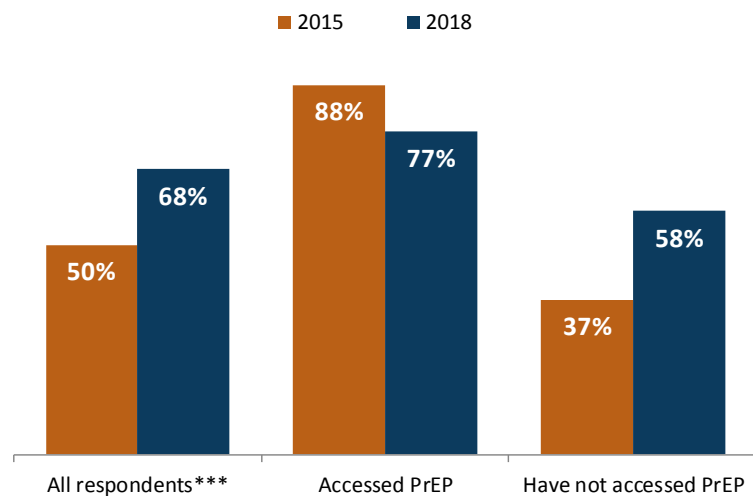
HIV Testing

Strut recommends that HIV-negative participants get tested for HIV every three months. The frequency of HIV testing among HIV-negative participants has increased since 2015. Among all participants, **68% reported testing in the past three months in 2018, compared to 50% of participants in 2015**. In contrast, the percentage of NHBS respondents that has been tested in the past three months decreased. While it was similar to Strut at Time 1, the percentage of NHBS respondents who had been tested in the past three months *decreased* by more than 15 percentage points at Time 2.

¹⁸ For both years, this variable is reported only for respondents who had been accessing services for at least three months.

The rate of HIV testing among Strut participants who have accessed PrEP within the last three months is consistently higher than that among non-PrEP users, which is likely driven by the testing requirements for PrEP treatment. However, while HIV testing rates among non-PrEP users *increased* between 2015 and 2018, testing rates among participants who have taken PrEP in the past 12 months decreased during this time period. The increase in testing overall and among non-PrEP users may be driven by an expansion in the accessibility and volume of testing available at the clinic, and increased STI exposure, symptoms, and diagnoses in the participant population at large, which has led to more traffic in the clinic.

Exhibit 8. HIV Testing Within Past Three Months¹⁹



***p<.001;

There is a statistically significant difference in HIV testing rates among those who have accessed PrEP compared to those who have not accessed PrEP (p<.001)

All respondents: 2015 n=254; 2018 n=620

Accessed PrEP (within past 12 months): 2015 n=69; 2018 n=220

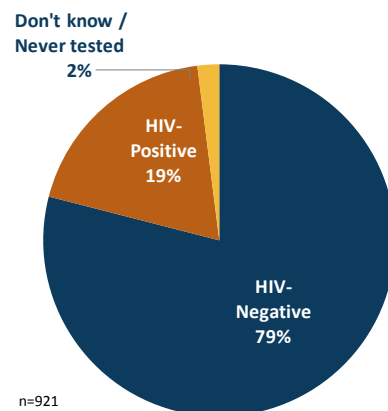
Have **not** accessed PrEP (within past 12 months): 2015 n=180; 2018 n=226

The decrease in testing rates among PrEP users may be explained at least in part by the increased wait time for participants to schedule PrEP services. Because of the wait time, many PrEP users had an HIV test conducted within the previous four months, slightly longer than the recommended 3-month period. Since the time of data collection, PrEP Express had been rolled out, which makes it faster and easier for participants to access follow-up testing.

Treatment for HIV-positive Individuals

In addition to providing HIV prevention services, Strut offers care for people who are HIV-positive. Similar to 2015, **less than one-quarter of respondents (19%) report that they are HIV-positive** (compared to 18% in 2015) (Exhibit 9). **Most HIV-positive participants at Strut (75%) were diagnosed six years ago or longer** (Exhibit 10), which reflects the national trend of decreasing rates of new HIV infection among the population at large.

Exhibit 9. HIV Status²⁰

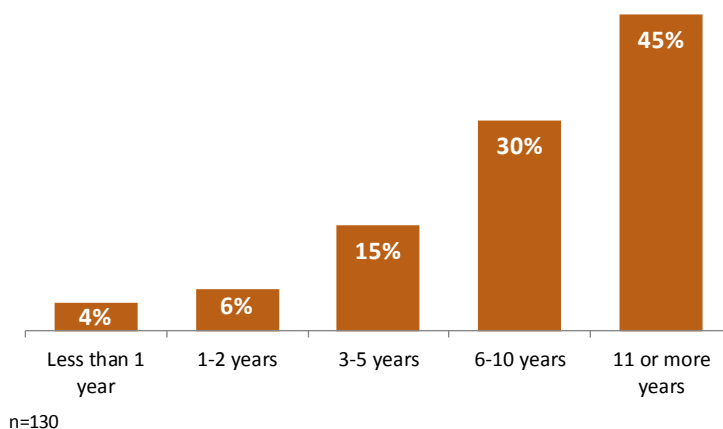


¹⁹ For both years, this variable is reported only for respondents who had been accessing services for at least three months.

²⁰ This variable is reported only for respondents who had been accessing services for at least three months.

During focus groups, participants spoke highly of 50-Plus, a group that fosters and supports the community of Strut participants over the age of 50, many of whom are HIV-positive. Participants value the opportunity to provide and receive support from other survivors, and the regular frequency with which the group meets.

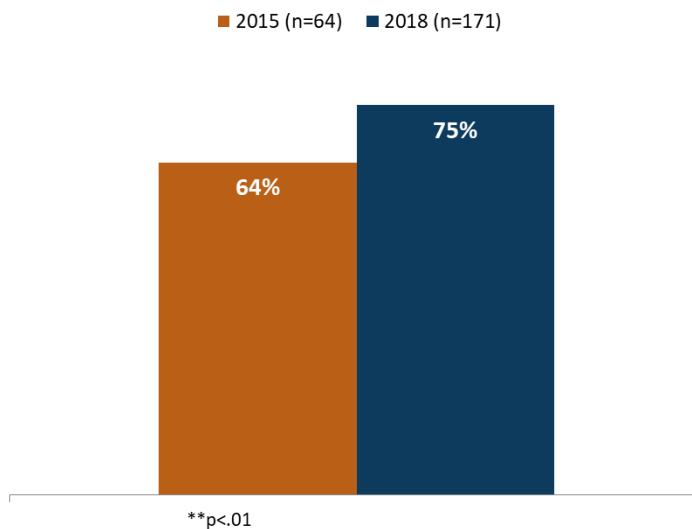
Exhibit 10. Length of HIV Diagnosis



Engagement in care remains high among HIV-positive clients. Among those who have accessed services at Strut for at least three months, HIV-positive clients report the following about their status and treatment:

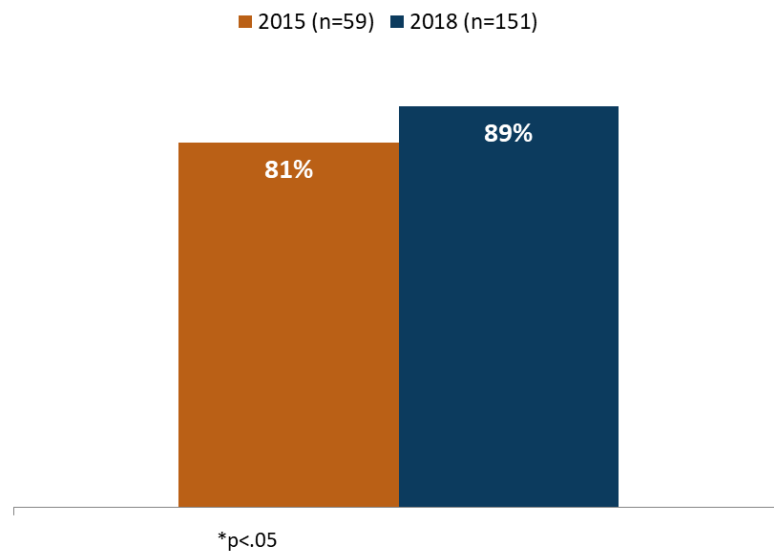
- **99%** of HIV-positive respondents have a **regular doctor or medical provider**, which is the same as 2015 (99%).
- **92%** of HIV-positive respondents **currently take HIV medications**, which is similar to 2015 (96%).
- Three-fourths (**75%**) of HIV-positive respondents report having a **medical visit within the past three months**, an increase from 2015 (64%) (Exhibit 11).

Exhibit 11. Visited Medical Provider Within Past Three Months**



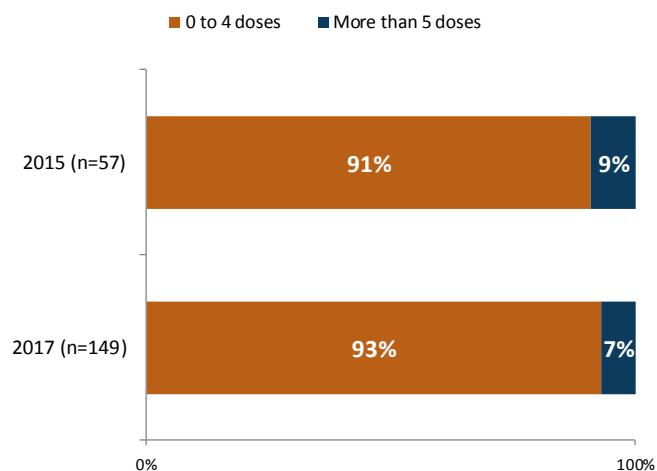
Nearly all (**89%**) **HIV-positive respondents** report being **virally suppressed**, which is a statistically significant increase from 2015 (81%)²¹ (Exhibit 12). While viral suppression rates are similar among the San Francisco MSM population represented in the NHBS sample, that rate has remained relatively constant over the same time period.

Exhibit 12. Viral Suppression Rates^{*22}



Nearly all (**93%**) respondents currently taking HIV medications **missed fewer than five doses of HIV medication** in the past month, which is similar to 2015 (91%) (Exhibit 13).

Exhibit 13. Number of Doses of HIV Medications Missed in the Past Month²³



²¹ For both years, this variable is reported only for respondents who had been accessing services for at least three months.

²² For both years, this variable is reported only for respondents who had been accessing services for at least three months.

²³ For both years, this variable is reported only for respondents who had been accessing services for at least three months.

Outcomes for Health Navigation Participants

Health Navigation provides support for HIV-positive individuals by assisting them in getting connected to medical care, enrolling in and obtaining health insurance, and accessing referrals to additional supports, such as mental health and housing assistance. When Strut first opened its doors, Health Navigation was a newly emerging program. Since that time, the program has grown substantially. Magnet and Health Navigation work together closely to ensure that all participants who are newly diagnosed as HIV-positive are referred to Health Navigation for support in getting connected to medical care. Participants with an existing diagnosis may be referred as well. Health Navigation is based out of the SFAF location at 1035 Market Street and provides services on site at Strut. SFAF and Strut are working to track key measures to identify how participants linked to and served by Health Navigation successfully connect with medical care. The data below, collected between January and March 2018, serve as a baseline:

- **90 participants** were served by Health Navigation (at any SFAF site); **38 also received a service(s) at Strut** (including engagement in any of the Strut programs)
- Among the 38 participants who accessed services at Strut, there were a total of **189 Health Navigation visits**
- **83% of participants referred** at Strut had a Health Navigation visit
- **50% of Health Navigation participants at Strut were linked to care** (attended an initial visit with a medical provider). This includes both clients previously and newly diagnosed. Among the six clients newly diagnosed with HIV, 83% were linked to care.

Sexual Risk

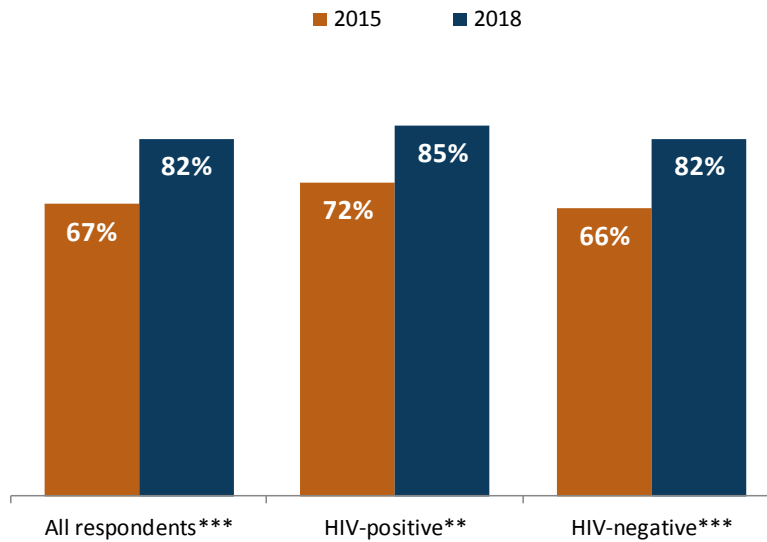
Strut tracks some key behavioral information from respondents to better understand their risk for sexual disease transmission. **Most respondents (82%) report having sex without a condom** in the past 12 months, a significant increase from 2015 (67%) (Exhibit 14).²⁴ However, condom use is still a risk reduction strategy for many clients: close to half (42%) report using condoms some of the time. This is a slight decrease from 2015 (50%). As discussed previously, the increase in PrEP use as a primary HIV prevention strategy may help to explain the trend in decreased condom use. When used properly, PrEP provides protection from HIV but does not prevent STI transmission.

Having sex with a person who injects drugs increases the risk of exposure to STIs and HIV. In 2018, **11%** of Strut respondents report having anal or vaginal **sex with a person who injects drugs** in the past 12 months.²⁵

²⁴ This data point was not collected for Magnet respondents in 2015, and thus the 2015 figure is not representative.

²⁵ This data point was not collected for Magnet respondents in 2015 and thus is not reported for that time point. It is reported only for respondents who had been accessing services for at least three months.

Exhibit 14. Condomless Sex Within the Past 12 Months**



p<.001; *p<.001

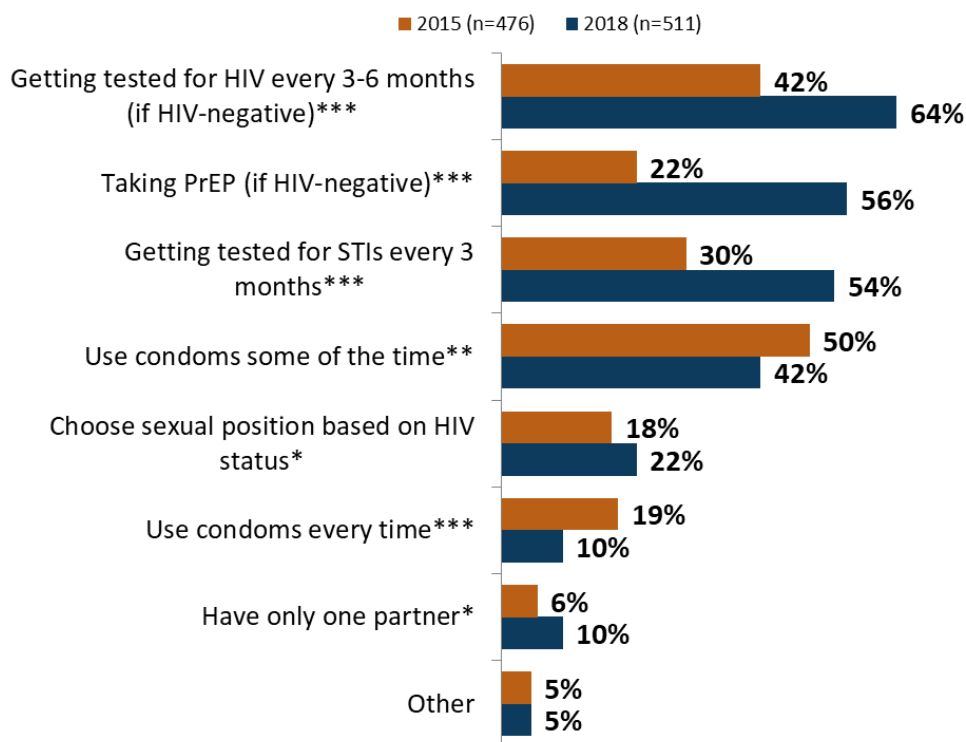
All respondents: 2015 n=464; 2018 n=1,116

HIV-positive: 2015 n=77; 2018 n=178

HIV-negative: 2015 n=368; 2018 n=918

There are several preventative strategies that Strut participants may use to decrease the risk of disease transmission with their sexual partners. The risk reduction strategies that respondents most commonly employ are **getting tested for HIV every 3-6 months (64%), taking PrEP (56%), and getting tested for STIs every three months (54%)**. Respondents use these strategies with significantly greater frequency compared to 2015. However, respondents are *less* likely to use condoms some or all of the time (Exhibit 15), as discussed above.

Exhibit 15. Sexual Risk Reduction Strategies



*p<.05; **p<.01; ***p<.001

Note: Percentages do not sum to 100% because respondents were asked to select all responses that apply. The percentages for “Taking PrEP” do not match the percentages reflected in Exhibit 6 for two reasons: 1. For 2018, respondents were asked about PrEP use as a separate question; these data are represented in Exhibit 6. 2. For Exhibit 6, only respondents who have accessed services for 3 months or longer are included in the findings for 2015 and 2018.

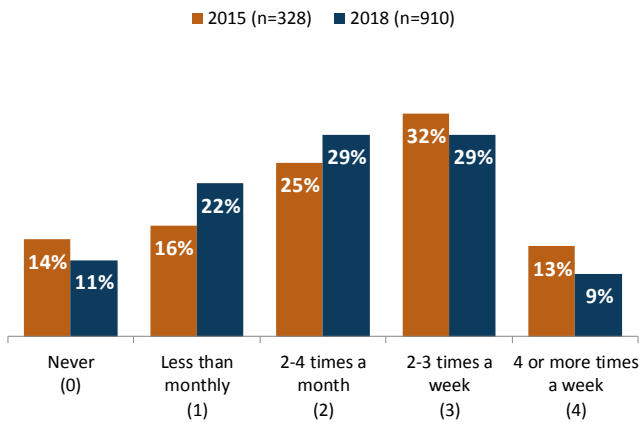
Substance Use

Among Strut respondents, substance use is common and problematic for some. This may be especially true for participants in Stonewall, a harm reduction alcohol and drug treatment program and DREAM, which has been increasing outreach to young black men with high needs, including challenges with substance use. In 2016 Strut launched Cheers Queers, a brief one-on-one harm reduction intervention designed to support participants to reduce binge drinking. In early 2018, Strut launched Healthy Works, a program focused on increasing access to syringes and NARCAN for people who inject drugs (PWID) in the Castro.

In 2018, **7% of respondents reported that they were currently in a program or receiving services for alcohol use, which is similar to 2015 (5%).**²⁶ In 2018, respondents appear to engage in less excessive drinking patterns, compared to 2015. For example, **4% of respondents report having six or more drinks on one occasion on a weekly basis, compared to 10% of respondents in 2015.** There was, however, a comparable increase in participants who report having six or more drinks on one occasion monthly (Exhibit 17).

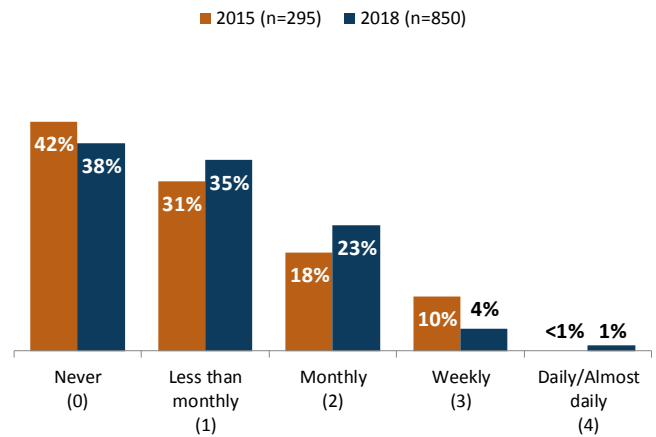
²⁶ For both years, this variable is reported only for respondents who had been accessing services for at least three months.

Exhibit 16. Frequency of Alcohol Use*²⁷



*p<.05

Exhibit 17. Frequency of Having Six or More Drinks on One Occasion*²⁸



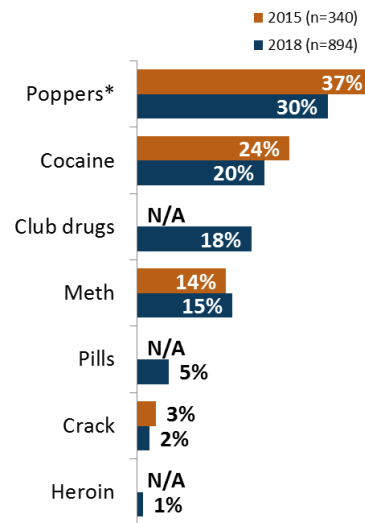
*p<.05

In general, **drug use among respondents has decreased somewhat compared to 2015.**

One exception is meth use, which has stayed relatively constant (15% in 2018, 14% in 2015) (Exhibit 18). **The drugs participants most commonly report using are poppers (37%), cocaine (20%), and club drugs (18%).** Drug use among the NHBS sample is generally higher than among the Strut sample, with rates of meth, coke, crack, and poppers at five to 15 percentage points higher among NHBS respondents than among Strut respondents.³⁰

A small group of respondents, 6%, report injecting drugs in both 2018 and 2015.³¹ Among Strut respondents who inject drugs, 1% shared needles to inject drugs in the past 12 months, similar to 2015 (2%).

Exhibit 18. Substances Used Within Past 12 Months²⁹



*p<.05

Note: Percentages do not sum to 100% because respondents were asked to select all responses that apply. N values vary because responses options were not uniform across the data collection instruments.

²⁷ For both years, this variable is reported only for respondents who had been accessing services for at least three months.

²⁸ For both years, this variable is reported only for respondents who had been accessing services for at least three months.

²⁹ For both years, this variable is reported only for respondents who had been accessing services for at least three months.

³⁰ These differences reflect those in the PSM sample comparisons. Differences are statistically significant (meth: p<.001; coke: p<.01; crack: p<.05; poppers: p<.05).

³¹ For both years, this variable is reported only for respondents who had been accessing services for at least three months.

Mental Health and Social Support

Strut aims to support participants' emotional and physical health by linking them to needed mental health services. Stonewall participants are eligible to receive support through participation in individual counseling sessions and support groups, while participants in other programs may be referred to mental health services outside of Strut.

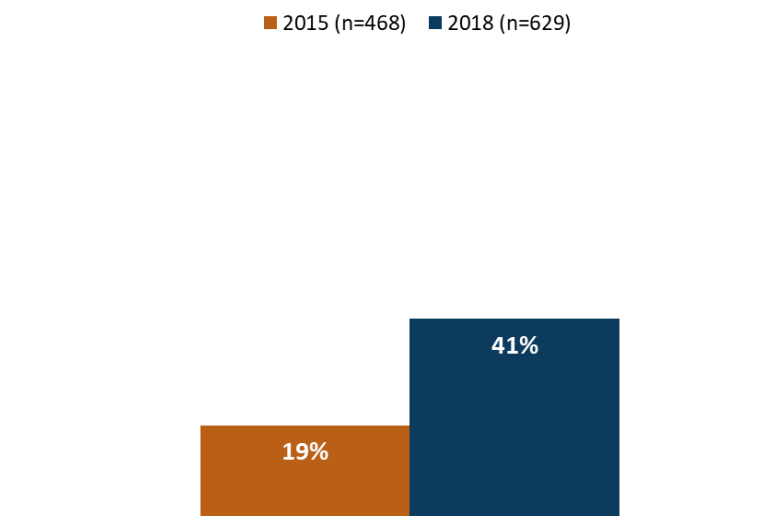
Strut staff and participants pointed out the **need for mental health support for a broader range of participants**. One staff member suggested having at least one mental health clinician on staff to assist when someone is in crisis. A few participants expressed a **need for case management support**, particularly related to supporting people with securing permanent housing.

In 2018, 32% of respondents reported that they were currently receiving mental health services, compared to 17% in 2015. The percentage of

respondents who reported feeling down, depressed, or hopeless in the past month doubled from 2015 to 2018 (Exhibit 19). This increase may be partially explained by the fear and confusion that many LGBTQ people are experiencing during the Trump administration, and the challenges of living in an increasingly unaffordable and rapidly-gentrifying urban area.

In accordance with these trends, respondents report somewhat less resilience compared to 2015. 80% of respondents say that they "tend to bounce back after illness or hardship" "often" or "nearly all the time," a slight decrease from 86% in 2015.

Exhibit 19. Feeling Down, Depressed, or Hopeless During the Past Month***



***p<.001

Exhibit 20. Respondent Resilience

	Year	(1) Not true at all	(2) Rarely true	(3) Sometimes true	(4) Often true	(5) True nearly all the time	Mean
I tend to bounce back after illness or hardship***	2015 (n=457)	0%	1%	13%	40%	46%	4.3
	2018 (n=614)	2%	1%	17%	47%	33%	4.1

***p<.001

As a complement to traditional mental health services, Strut supports participants to foster critical social supports, through formal groups, community events, and informal interactions in the Strut space. Strut programs have helped many participants to access a welcoming, compassionate community that promotes health and offers needed emotional support. Several participants spoke warmly of the deep friendships they have cultivated through participation in Strut programs. Participants who are part of **groups that meet regularly**, such as 50-Plus and Stonewall groups, have formed especially close connections.

Strut-wide activities and events have helped to foster a greater sense of community among staff and participants across programs, as well as among other community members who attend. Staff have noticed a continued **increase in attendance at groups and community events** across programs.

Strut measures social support using a set of five questions that gather information about the frequency with which various forms of social support are available to respondents. Participants report relatively high levels of some types of social supports; for example, **73% of respondents report that they have someone to confide in or talk to about problems “most of the time” or “all of the time.”** However, respondents have less support in other areas. Most notably, **17% of respondents report having someone to help with chores if they are sick “none of the time.”**

Exhibit 21. Availability of Social Supports

		(1)	(2)	(3)	(4)	(5)	
	Data Year	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Mean
I have someone to turn to for suggestions on how to deal with a personal problem**	2015 (n=458)	4%	8%	12%	27%	50%	4.1
	2018 (n=619)	5%	9%	15%	36%	36%	3.9
I have someone to confide in or talk to about my problems*	2015 (n=459)	3%	6%	14%	30%	47%	4.1
	2018 (n=617)	2%	7%	18%	38%	35%	4.0
I have someone to get together with for relaxation***	2015 (n=459)	2%	11%	18%	31%	38%	3.9
	2018 (n=620)	3%	13%	24%	32%	27%	3.7
I have someone to love and make me feel wanted*	2015 (n=456)	8%	11%	15%	19%	47%	3.9
	2018 (n=617)	7%	13%	22%	22%	37%	3.7
I have someone to help me with chores if I were sick***	2015 (n=458)	12%	14%	15%	26%	34%	3.6
	2018 (n=619)	17%	20%	19%	22%	23%	3.1

*p<.05; **p<.01; ***p<.001

Note: Percentages may not sum to 100% due to rounding.

Internal Operations and Cross-Program Collaboration

Since Strut first opened, staff and participants have developed more comfort in the space and increasingly **stronger relationships across programs**. Several factors have contributed to this shift, including strong and thoughtful leadership, clearer building policies and internal processes, and more familiarity and connection among staff and participants across programs.

Strut staff have been very happy with the current organizational leadership, which has brought energy, agency in their roles, and an attentiveness to the needs and ideas of staff. Leaders have helped to bring increased clarity to building policies and internal processes. Shortly after Strut opened, staff shared numerous concerns, including challenges with the use of shared programming space, lack of clarity with internal referral processes, and the absence of leadership presence in the building. These concerns have been replaced by an overall sentiment of confidence in Strut leaders and the changes they've brought.

As internal processes and procedures have become clearer, Strut programs have been able to more effectively collaborate to serve participants better. A key goal of the Strut model is to connect participants to services and activities across programs. For example, a participant who visits Magnet for STI testing could learn about DREAAM during their clinic visit and receive a recommendation to attend an upcoming DREAAM group activity. As program staff have become more knowledgeable of other programs' offerings, there have been more internal referrals and cross-program collaboration to plan events and activities. In 2018, 25% of SFAF participants in community engagement programs (Bridgemen, 50-Plus, and DREAAM) also received an additional service such as PrEP, Health Navigation, or HIV/STI testing. While 2015 data are not available, staff and participants report that participants are now accessing services across programs at higher rates.

Stronger staff relationships also facilitate more warm hand-offs to connect participants across programs. Staff note that these trusting working relationships have increased their comfort referring participants to other programs because they feel a greater sense of confidence that the staff from other programs will provide high-quality services to the participants they refer.

Participants report that they **value staff referrals and recommendations** to internal programs and activities as well as to services and resources outside of Strut. As in prior years, when asked about referrals, participants largely cited announcements they had heard to attend events rather than personalized referrals across programs. However, some participants, particularly those who are fairly new to Strut, are **unfamiliar with the range of service offerings and programs** offered at Strut. As in the past, participants recommend that a **full list of programs and service offerings be posted** in the main lobby at Strut. They also suggested that the **calendar on the Strut website, social media, email, newsletters, and local newspapers** can be valuable for spreading information about programs and events.

Community Partnerships

San Francisco is home to a diverse and committed network of organizations that provide critical services to the LGBTQ community. An established and well-known institution in this landscape, SFAF and Strut are interested to learn more about how they can be a strong partner and collaboratively serve the LGBTQ community even better. External stakeholders report that the current leadership at SFAF is **more humble, open to new ideas, and interested in collaborating** with other LGBTQ organizations in the community, compared to past leadership. Two stakeholders shared the opinion that Strut operated largely

independently under previous leadership and thought there had been inadequate attention and energy dedicated to cultivating community partnerships; another felt that SFAF had failed to accept input from community organizations while making plans for the new model and building at Strut.

Looking to the future, stakeholders invited Strut to **cultivate a deeper commitment to interdependence and partnership** with other organizations serving the LGBTQ community in San Francisco. This includes being in closer communication with existing partners about program changes, inviting and stepping into opportunities to collaborate with new and existing partners, and stepping back to learn and receive input from other providers. Additionally, as Strut considers how best to serve a more diverse clientele, they have an opportunity to be in conversation with and learn from other service providers in San Francisco that have historically served these populations. This is critical to ensuring that providers are collectively meeting the needs of the community in an **intentional and integrated way**, and that they honor and learn from each other's experience and areas of expertise.

Strut is also committed to receiving feedback and input about the impact that they have on neighboring institutions and individuals in the Castro. Stakeholders in the Castro identify Strut as a **supportive and positive neighbor**. Strut helps to generate foot traffic in the neighborhood, which supports a vibrant community atmosphere and boosts sales for local businesses. Stakeholders identify Strut as contributing to the well-being of the Castro community by providing essential and high-quality sexual health services in the neighborhood. One stakeholder emphasized that Strut fills an important gap in the neighborhood as a place where people can find respite off the street and appreciates that Strut is welcoming to the homeless and mentally ill, while ensuring that there are boundaries set for behaviors within the building. Finally, one stakeholder spoke to the value of Strut's role in maintaining the Castro's identity as an "LGBT hub" in San Francisco, particularly in light of the changing demographics in the neighborhood.

III. Recommendations

As Strut continues to learn about program outcomes and participants' evolving needs, leadership may consider the following opportunities to better serve participants at Strut and in the wider network of care in San Francisco.

- **Explore strategies for supporting clients with mental health and social support needs.** An increasing number of Strut clients report depression, social isolation, and mental health needs. The driver behind this change is not clear, nor whether it's reflective of trends among the broader population or of a shift in the composition of the Strut population. Given the level of need for mental health supports, Strut is encouraged to explore options for connecting clients with counseling services. Strut could consider expanding existing support groups and programs to different client populations to increase opportunities to build social connections and supports.
- **Maintain commitment to innovation and responsiveness to meet client needs and expand care.** Strut leadership have been nimble and innovative in their approach to increasing clinic capacity and enhancing care, for example through the launch of Magnet Express and by expanding anal and vaginal health services. We encourage Strut to continue to be responsive and creative, particularly in this constantly evolving health landscape. On the horizon, Strut has plans to launch PrEP case management in Fall 2018. This program will help to address the needs of HIV-negative participants, including supporting those who may struggle with PrEP adherence.
- **Continue to bring staff together and facilitate relationship building and inform clients of services available.** Current Strut leadership have demonstrated a strong commitment to fostering increased integration of programs and services at Strut. Efforts to build connections among staff across different programs have contributed to increased knowledge of the range of programs and services in the building and referral processes, as well as increased trust among staff, which has fostered more cross-program referrals and inter-program collaboration. For example, since late September, Magnet, Stonewall, health navigation, DREAAM, and the PrEP program have collaborated to host QTPOC Night, a weekly event to support queer and trans people of color. However, many participants still do not know about all of Strut's services and programs and there is room for further growth in education and outreach to participants. Continued commitment to bringing staff together will maintain the momentum for cross-program collaboration and service integration.
- **Continue to define target populations and Strut's approach for strengthening the broader system of care in San Francisco.**
- As Strut evolves, leaders continue to explore who the specific target populations are and how to ensure that care for all is accessible and client-centered. While Strut is now clinically equipped to serve cis women and trans women, and staff have become more skilled and comfortable working with these clients, Strut will need to continue to consider the extent to which they engage in outreach to these communities. Strut functions within a larger landscape of providers in San Francisco and serves clients both directly and also by supporting their partner organizations. Continued relationship building, partnership, engagement, and coordination with other providers in the city could contribute to the strengthening of the system of care city-wide. A recent example of such a collaboration is Strut's partnership with Castro Cares to provide weekly syringe access and conduct outreach to people who inject drugs and/or are homeless.
- **Continue to actively promote sexual health and sex positive messaging.** Strut actively encourages STI prevention, testing, and treatment for participants. For example, the [Douchie](#) campaign that focused on anal health gained notable traction in the summer of 2018. As condom use among Strut participants decreases, continued emphasis on STI prevention is essential. Participants encourage

Strut to ensure consistent attention to STI prevention and care, in addition to the current strong messaging about PrEP. Strut can also be a leader in STI prevention more broadly; as external stakeholders conveyed, Strut is well positioned to be vocal about this message in their broader community and City communications.

- **Explore opportunities to strengthen and build partnerships with organizations from the greater Bay Area to address needs of clients who are not San Francisco residents.** Strut has seen a large increase in participants from outside of San Francisco. Further, last year, 60% of newly diagnosed HIV cases were people from outside of San Francisco, most of whom were from the Bay Area. The increased demand for services from non-residents suggests that Strut is meeting a need among populations that were either not accessing services prior, or who were not satisfied with the services they were receiving. While the factors driving the trend are not clear, it is likely that Strut's reputation for affordable and client-centered care is attracting new participants, as well as Strut's high levels of PrEP service provision. To support the ongoing and comprehensive care of these participants – and especially for HIV-positive clients who need to be engaged in regular care – there could be value in Strut exploring opportunities to strengthen and build new partnerships with sexual health and HIV prevention and treatment organizations in the greater Bay Area. Strut can reach out to its existing partners in the East Bay– East Bay AIDS Center (EBAC), Oakland LGBT Center, Gender Equity Resource Center (through UC Berkeley), and Pacific Center – to continue or initiate conversations about how to link people to needed health services. Strengthening these partnerships and building new ones would extend the network of providers and services to which Strut could refer and connect participants, particularly in cases where they are seeking care additional care closer to their home. Strut may also consider gathering information from non-San Francisco participants to better understand how they have chosen to access services at Strut and where they have accessed services in the past. Better understanding the factors that are drawing participants to Strut would help Strut both better understand the gaps in services that it is filling and also inform opportunities for partnerships in other cities.

IV. Next Steps

This report serves as the culmination of the evaluation that San Francisco AIDS Foundation and Learning for Action partnered on to describe the outcomes of the Strut model in 2018, approximately two years after the new integrated model at Strut opened. Strut can use these findings to communicate to internal and external audiences about the key successes and outcomes of their model, the areas they would like to see improved outcomes, and the questions that they are grappling with.

These findings also serve as benchmark by which Strut can compare the population accessing services at Strut, participant service usage, and participant outcomes in future years. As Strut continues to refine their data collection across programs, including transitioning programs onto the Electronic Health Records system, they will have even more complete and consistent data across all programs.

Learning for Action also invites and encourages Strut to continue to invite reflection and feedback from staff and participants, through formal interviews or focus groups with a third party evaluator, or more informal methods such as staff-led discussions. By continuing these ongoing learning and reflection processes, Strut can continue to assess their successes and opportunities for continued improvements to their programs, services, and engagement with the Castro community and other providers in the San Francisco HIV prevention landscape.

V. Appendix

Additional Findings

This appendix includes aggregate data for the CVEQ variables that are not included in the body of this report.

Program Participation

Exhibit 22. Ways Respondents Heard about Program of Enrollment

Percent of respondents	
A friend	60%
My doctor	6%
Another agency	4%
Another SFAF program	1%
SFAF website	0%
Other internet source	20%
Twitter	0%
Walked by	0%
Other	9%

n=188

Exhibit 23. Length of Involvement with Program

Percent of respondents	
Less than three months	18%
3-6 months	7%
6 months to 1 year	12%
1-2 years	23%
More than 2 years	39%

n=624

Exhibit 24. Frequency of Participation in Program Activities

Percent of respondents	
Once a year or less	9%
2 to 3 times a year	17%
Around every 3 months	35%
Around once a month	19%
Around once a week	21%

n=950