File No. 121072

Committee Item No. 3
Board Item No. 29

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget and Finance Committee **Date** 11/14/2012

Board of Supervisors Meeting **Date** November 20, 2012

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Completed by: Victor Young **Date** November 9, 2012
Completed by: Victor Young **Date** 11-15-12

FILE NO. 121072 RESOLUTION NO.

[Accept and Expend Grant - Medical Monitoring Project - $196,104]

Resolution authorizing the San Francisco Department of Public Health to retroactively accept and expend a grant in the amount of $196,104 from Centers for Disease Control and Prevention to participate in a program entitled Medical Monitoring Project for the period of June 1, 2012, through May 31, 2013.

WHEREAS, The Centers for Disease Control and Prevention (CDC) has agreed to fund Department of Public Health (DPH) in the amount of $196,104 for the period of June 1, 2012, through May 31, 2013; and

WHEREAS, As a condition of receiving the grant funds, CDC requires the City to enter into an agreement (Agreement), a copy of which is on file with the Clerk of the Board of Supervisors in File No. 121072; which is hereby declared to be a part of this Resolution as if set forth fully herein; and

WHEREAS, The purpose of this project is to provide a population-based sample of HIV-infected persons who are receiving medical care; and

WHEREAS, DPH will subcontract with Public Health Foundation Enterprises, Inc. in the total amount of $111,403; for the period of June 1, 2012 through, May 31, 2013; and

WHEREAS, An Annual Salary Ordinance amendment is not required as the grant partially reimburses DPH for three existing positions, one Manager I (Job Class No. 0922) at .15 FTE, one Health Program Coordinator III (Job Class No. 2593) at .25 FTE and one Health Program Coordinator I (Job Class No. 2589) at .10 FTE for the period of June 1, 2012 through, May 31, 2013; and

File Number: _____
(Provided by Clerk of Board of Supervisors)

Grant Resolution Information Form
(Effective July 2011)

Purpose: Accompanies proposed Board of Supervisors resolutions authorizing a Department to accept and expend grant funds.

The following describes the grant referred to in the accompanying resolution:

1. Grant Title: **Medical Monitoring Project (MMP)**

2. Department: **Department of Public Health**
AIDS Office
HIV Epidemiology Section

3. Contact Person: **Maree Kay Parisi** Telephone: **415-554-9095**

4. Grant Approval Status (check one):

[X] Approved by funding agency [ ] Not yet approved

5. Amount of Grant Funding Approved or Applied for: **$196,104 Supplemental fund**

6a. Matching Funds Required: **$0**
b. Source(s) of matching funds (if applicable):

7a. Grant Source Agency: **Centers of Disease Control and Prevention**
b. Grant Pass-Through Agency (if applicable):

8. Proposed Grant Project Summary: **The Medical monitoring Project (MMP) is a CDC-funded, multi-site HIV supplemental surveillance activity in which a multistage sampling scheme is used to provide a population-based sample of HIV-infected persons who are receiving medical care.**

9. Grant Project Schedule, as allowed in approval documents, or as proposed:

Start-Date: **06/01/2012** End-Date: **05/31/2013**

10a. Amount budgeted for contractual services: **$111,403**

b. Will contractual services be put out to bid? **No**

c. If so, will contract services help to further the goals of the Department's Local Business Enterprise (LBE) requirements? **N/A**

d. Is this likely to be a one-time or ongoing request for contracting out? **N/A**

11a. Does the budget include indirect costs? [X] Yes [ ] No

b1. If yes, how much? **$11,797**
b2. How was the amount calculated? **24.84% of total salaries**

c1. If no, why are indirect costs not included?
[ ] Not allowed by granting agency [ ] To maximize use of grant funds on direct services
[ ] Other (please explain):

c2. If no indirect costs are included, what would have been the indirect costs?

WHEREAS, A request for retroactive approval is being sought because DPH did not receive notification of the agreement until June 28, 2012, for a project start date of June 1, 2012; and

WHEREAS, The budget includes a provision for indirect costs in the amount of $11,797; now, therefore, be it

RESOLVED, That DPH is hereby authorized to retroactively accept and expend a grant in the amount of $196,104 from CDC; and, be it

FURTHER RESOLVED, That DPH is hereby authorized to retroactively accept and expend the grant funds pursuant to San Francisco Administrative Code section 10.170-1; and, be it

FURTHER RESOLVED, That the Director of Health is authorized to enter into the Agreement on behalf of the City.

RECOMMENDED:

for

Barbara A. Garcia, MPA
Director of Health

APPROVED:

Office of the Mayor

Office of the Controller

12. Any other significant grant requirements or comments:

We respectfully request for approval to accept and expend these funds retroactive to June 01, 2012. The Department received the subaward agreement on June 28, 2012.

Grant Code: HCAO05/1200

****Disability Access Checklist***(Department must forward a copy of all completed Grant Information Forms to the Mayor's Office of Disability)**

13. This Grant is intended for activities at (check all that apply):

[X] Existing Site(s)
[ ] Rehabilitated Site(s)
[ ] New Site(s)
[ ] Existing Structure(s)
] Rehabilitated Structure(s)
[ ] New Structure(s)
[ ] Existing Program(s) or Service(s)
[ ] New Program(s) or Service(s)

14. The Departmental ADA Coordinator or the Mayor's Office on Disability have reviewed the proposal and concluded that the project as proposed will be in compliance with the Americans with Disabilities Act and all other Federal, State and local disability rights laws and regulations and will allow the full inclusion of persons with disabilities. These requirements include, but are not limited to:

1. Having staff trained in how to provide reasonable modifications in policies, practices and procedures;
2. Having auxiliary aids and services available in a timely manner in order to ensure communication access;
3. Ensuring that any service areas and related facilities open to the public are architecturally accessible and have been inspected and approved by the DPW Access Compliance Officer or the Mayor's Office on Disability Compliance Officers.

If such access would be technically infeasible, this is described in the comments section below:

Comments:

Departmental ADA Coordinator or Mayor's Office of Disability Reviewer:

Jason Hashimoto
(Name)

Director, EEO, and Cultural Competency Programs
(Title)

Date Reviewed: 10/10/12

(Signature Required)

Department Head or Designee Approval of Grant Information Form:

Barbara A. Garcia, MPA
(Name)

Director of Health
(Title)

Date Reviewed: 10/10/12

for
(Signature Required)

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
AIDS Office - HIV Surveillance Section
Medical Monitoring Project (MMP) Supplement
06/1/12-5/31/13

Dept / Div: *HPH-03*
Fund Group: *2S/CHS/GNC*
Index Code: *HCHPDHIVSVGR*
Grant Code: *HCAO05*
Grant Detail: *1200*

CATEGORY/LINE ITEM	Annual Salary	42.00% Annual Frin Ben	Total Annual Sal/Frin Ben	% OF TIME	% OF FTE	Monthly Rate	Mth	Salary Budget	Frin Ben Budget	Total Budget
A. PERSONNEL										
HIV SURVEILLANCE UNIT										
1. Manager II 0923 2 S. Scheer	112,155	47,105	159,260	15%	0.15	9,346	12	16,823	7,066	23,889
2 Health Program Coordinator III 2593 5 m Parisi	93,543	39,288	132,831	25%	0.25	7,795	12	23,386	9,822	33,208
3 Health Program Coordinator I 2589 5 A. Buckman	72,815	30,582	103,397	10%	0.10	6,068	12	7,281	3,059	10,340
4										
5 COLA 4%										
6 STEP Increases 5%	0	0	0	0%	0.00	0	0	0	0	0
TOTAL SALARY/FRINGE	**278,513**	**116,975**	**395,488**		**0.50**			**47,490**	**19,946**	**67,436**

00101 SALARIES	47,490
00103 FRNG BN	19,946
SUB TOTAL	**67,436**

1230

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
AIDS Office - HIV Surveillance Section
Medical Monitoring Project (MMP) Supplement
06/1/12-5/31/13

Dept / Div: *HPH-03*
Fund Group: *2S/CHS/GNC*
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Grant Detail: *1200*

CATEGORY/LINE ITEM	Annual Salary	42.00% Annual Frin Ben	Total Annual Sal/Frin Ben	% OF TIME	% OF FTE	Monthly Rate	Mth	Salary Budget	Frin Ben Budget	Total Budget
C. TRAVEL										
1. Local Travel (02301)										
2. Out-of-Jurisdiction Travel (02101)										5,468
Sub Total TRAVEL										5,468
D. EQUIPMENT										
1. Computers/Servers (06061)										0
Sub Total EQUIPMENT										0
E. MATERIALS AND SUPPLIES										
1. Office supplies (04951)										0
Sub Total SUPPLIES										0
F. CONTRACTUAL SERVICES (02789)										
1. Public Health Foundation										111,403
2.										
Sub Total CONTRACTS										111,403
G. OTHER										
1. Rent support/mtg fac (03011)										0
2. Telephone/Com (03241)										0
3. Postage (03561)/Freight (03521)										0
4. Delivery/Courier srvc (03521)										0
5. Reproduction/Photocopy										0
a. Photocopier leasing (03131)										0
b. Photocopier maint (02931)										0
c. Repro srvc (In House)(081PR)										0
6. Print/Slide srvc (Outside)(03552)										
7. Subscriptions (03571)										0
8. Interpretation (02799)										0
9. Staff training (02201)										0
10. Membership (02401)										0
11. Stipend (02783)										0
12. MIS Services (ACE)(02789)										0
13. Other Fees/NDI Match (02699)/IRB Review (02799)										0
Sub TOTAL OTHER										0
TOTAL DIRECT COST										184,307

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
AIDS Office - HIV Surveillance Section
Medical Monitoring Project (MMP) Supplement
06/1/12-5/31/13

Dept / Div: *HPH-03*
Fund Group: *2S/CHS/GNC*
Index Code: *HCHPDHIVSVGR*
Grant Code: *HCAO05*
Grant Detail: *1200*

CATEGORY/LINE ITEM	Annual Salary	42.00% Annual Frin Ben	Total Annual Sal/Frin Ben	% OF TIME	% OF FTE	Monthly Rate	Mth	Salary Budget	Frin Ben Budget	Total Budget
			BUDGET SUMMARY							
			FTE =	0.50						
A. SALARIES										47,490
B. MANDATORY FRINGE										19,946
C. TRAVEL										5,468
D. EQUIPMENT										0
E. MATERIALS AND SUPPLIES										0
F. CONTRACT / MOU										111,403
G. OTHER										0
DIRECT COSTS										184,307
H. INDIRECT COST (24.84% of total salaries)										11,797
TOTAL BUDGET										**196,104**
AWARD										**196,104**
SURPL/(DEFICFIT)										**0**

San Francisco Department of Public Health AIDS Office
HIV Epidemiology Section
"Medical Monitoring Project (MMP) Supplement"
Grant Number CDC-RFA-PS09-937, 3U62PS001600-04S1
Budget Summary

June 1, 2012 - May 31, 2013

A.	Salaries	$47,490
B.	Mandatory Fringe	$19,946
C.	Travel	$5,468
D.	Equipment	$0
E.	Materials and Supplies	$0
F.	Contractual	$111,403
G.	Other Expenses	$0
	TOTAL DIRECT COSTS	$184,307
H.	Indirect Costs (24.84% of Total Salaries)	$11,797
	TOTAL BUDGET	**$196,104**

Detail Line-Item Budget and Justification: 6/1/2012 – 5/31/2013

A.	**PERSONNEL**	**$47,490**
B.	**MANDATORY FRINGE**	**$19,946** (42% of salaries)

1. 0922 – Manager I: Susan Scheer
   HIV Epidemiology Section Director
   Annual Salary: $112,155 x 0.15 FTE x 12 months = $16,823

The Principal Investigator will be responsible for ensuring that all MMP protocols are followed and that the necessary security and confidentiality standards are met. She will be responsible for ensuring that all the necessary institutional review board (IRB) approvals are granted and for keeping these current throughout the project period and will communicate any protocol modifications and/or violations to the appropriate IRBs. She will serve as the project liaison to the SFDPH HIV/AIDS core and incidence surveillance programs and make sure that MMP is integrated, to extent possible, with core surveillance. She will disseminate the MMP findings to the San Francisco Care Council, HIV Prevention Planning Council and other interested parties. She will be responsible for the fiscal management of MMP and will assist the MMP project coordinator with hiring of staff.

2. 2593 - Health Program Coordinator III: Maree Kay Parisi
   MMP Project Director
   Annual Salary: $93,543 x 0.25 FTE x12 months=$23,386

Principal duties include coordinating the MMP activities. She will work with others to create a comprehensive list of providers from hospital websites to incorporate into sampling frame. She will be responsible for negotiating with sites to participate in the MMP, processing and managing MOUs and contracts, identifying key personnel at provider sites, conducting site visits to ensure adherence to protocols and to identify and resolve problems. She will educate providers regarding the project and set up a stipend system for participants who participate in the project. She will conduct chart abstraction and interview participants as well as supervise field staff who will be doing chart reviews and interviewing participants. She will monitor and oversee participation of patients. She will work with the Principal Investigator in presenting data to stakeholders and in answering questions for prospective providers and participants. She will be working in clinics, hospitals, and private medical providers' offices conducting interviews, active HIV/AIDS surveillance, and MMP.

3. 2589 – Health Program Coordinator I: Tony Buckman
   Annual Salary: $72,815 x 0.10 FTE x12 months=$7,281

The Health Program Coordinator will work with provider sites who have requested help with recruitment by obtaining phone numbers of patients, phoning

patients on behalf of the medical providers to introduce and recruit patients into MMP. He will follow protocol on documenting outcomes of his recruitment efforts to MMP staff. He will also follow up with provider sites that have not requested assistance with recruitment, and explain the assistance he can provide.

C. TRAVEL **$5,468**

1. Out-of-Jurisdiction Travel

To cover costs of domestic travel to CDC meetings for the principal investigator health program coordinator I and project coordinator to attend the MMP meeting in Atlanta. Estimated costs are below.

Airfare ($800 x 3 staff) =	$2400
Lodging ($275/night x 3 nights x 3 staff) =	$2475
Ground Transportation ($198/person x 3 staff) =	$593
Total =	$5,468

D. EQUIPMENT **$0**

E. MATERIALS AND SUPPLIES **$0**

F. CONTRACTUAL **$111,403**

Name of contractor: Public Health Foundation Enterprises, Inc. (PHFE)

Method of Selection: We have a current working relationship with PHFE. PHFE was selected through a RFQ process in 2009. PHFE also provides staffing with expertise in database development, management and analysis as well staffing to conduct field activities.

Period of performance: 6/1/2012 – 5/31/2013

Description of activities: PHFE will provide the staffing for the development of the database and field activities: including medical record abstraction and patient interview. They have demonstrated expertise in this area and have an established relationship with the AIDS Office.

Method of accountability: The contractor will follow the CDC and HIV Epidemiology Section procedures; will follow strict performance timelines; contractor's performance will be monitored and evaluated by the senior epidemiologist; payment to contractor will be based on fee for service.

Itemized budget with narrative justification: $111,403

a) PHFE Personnel	$66,530
b) PHFE Mandatory Fringe Benefits	$20,001(30.0% of salaries)

i. Research Associate: TBD
Annual Salary: $43,919 x 1.0 FTE for 12 months = $43,919

Under the supervision of the MMP project coordinator, the employee will be working in clinics, hospitals, and private medical provider's offices conducting interviews, recruiting participants and conducting chart abstraction.

ii. Data Manager: Jennie Chin
Annual Salary: $83,992 x 0.2692 FTE for 12 months = $22,611

In order to provide back-up and coverage for the MMP data Manager/epidemiologist, this data manager will spend 25% of her time for assisting the MMP data manager/epidemiologist with processing and managing the MMP sampling frame, interview and abstraction data, patient and facility tracking systems and SAS coding for analyses. She will assist with back-up for the MMP data manager/epidemiologist for forwarding data to the CDC and to communicate with CDC regarding data management issues.

c) PHFE Travel $1,423

i. Out-of-Jurisdiction Travel $1,423

Funds will cover costs of domestic travel to CDC training for the Research Associate. Estimated costs are below.

Airfare ($650 x 1 staff) =	$650
Lodging ($133/night x 3 nights x 1 staff) =	$399
Per Diem ($56/day x 4 days x 1 staff) =	$224
Ground Transportation ($150/person x 1 staff) =	$150
Total =	$1,423

d) PHFE Equipment $0

e) PHFE Materials and Supplies $5,290

i. IT Supplies $5,290

Costs associated with purchasing one new desktop, one laptop and one tablet as well as the necessary software for each. Costs estimated as follows.

Desktop and basic computer software: $1,500
Laptop and basic computer software: $2000
Tablet: $500
2 QDS Software licenses: $990
2 PGP Software licenses: $300

f) PHFE Contractual Services	$0
g) PHFE Other Expenses	$8,960
i. Participant Stipends	$8,000

Reimbursement provided to clients participating in the MMP. Participant will be given a cash stipend. 200 Participants x $40 Stipend/Participant = $8,000

ii. Courier	$960

Cost associated with mailing program related documents and delivery of petty cash for stipends. Costs estimated at $80 per month for 12 months.

Total PHFE Direct Costs	$102,205
h) Total PHFE Indirect Costs(@ 9% MTDC)	$9,198
Total PHFE Budget:	$111,403

G.	**OTHER**	**$0**
	TOTAL DIRECT EXPENSE:	**$184,307**
H.	**INDIRECT COST (24.84% of Total Salaries)**	**$11,797**
	TOTAL BUDGET:	**$196,104**

Supplement to HIV Medical Monitoring Project
Funding Opportunity Announcement CDC-RFA-PS09-9370401SUPP12
06/01/12-05/31/13

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ABSTRACT

The Medical Monitoring Project (MMP) is a CDC-funded, multi-site HIV supplemental surveillance activity in which a multistage sampling scheme is used to provide a population-based sample of HIV-infected persons who are receiving medical care. Sampled patients are recruited for an interview and medical chart abstraction to collect information on clinical outcomes, use of HIV medications, insurance status, unmet care needs, and frequency of HIV-related clinical testing. San Francisco is an MMP site. While MMP has provided important information on this population, it has missed HIV-diagnosed persons who either never received HIV-specific care or whose care has lapsed. In addition, sampling for MMP is labor intensive and costly. As such, assessing the feasibility of sampling facilities and/or patients directly from HIV case registries offers the potential of sampling a broader population in a more cost-effective manner. In this project, we will work with CDC to test the feasibility of sampling facilities and patients from the local HIV case registry as an alternative MMP sampling method. The current or last known health care provider for each sampled patient will be contacted to obtain updated patient contact information. Patients will be contacted by MMP staff and recruited for an interview and medical chart abstraction. Contact information for sampled patients will be obtained from the registry, health care provider, or from searching the electronic medical records of all San Francisco public clinic sites, databases for the HIV-related services, and a professional data aggregating system. Persons who are not in care will be linked to services. We will assess the effectiveness of this sampling method by quantifying the number and proportion of sampled patients who are successfully located and participate in MMP. We will quantify and characterize patients who are in care, were never in care, or whose care lapsed, and measure the proportion of persons who were not in care who were successfully linked to care.

BACKGROUND

San Francisco has been a participating site in the Medical Monitoring Project (MMP) since MMP's inception in 2007. MMP has provided important local and national information regarding the population of HIV diagnosed persons receiving care in health care settings, including information on clinical outcomes, use of HIV medications, insurance status, unmet care needs, and frequency of HIV-related clinical testing. Recently published results from MMP identified important unmet ancillary care needs such as case management and dental and mental health care [1]. Similar information has been reported from the San Francisco MMP [2-3]. While MMP has, and continues to provide essential information from persons in care, methods to collect similar information from persons diagnosed with HIV who are not in care is needed in order to have a complete measure of important clinical and prevention outcomes. This last point is increasingly vital as we move towards a model of early diagnosis, rapid linkage to care, and use of antiretroviral therapy to reduce morbidity, mortality, and HIV transmission.

San Francisco has been a leader in adopting a 'test and treat' model for the management of HIV disease and control of the epidemic. In a collaborative effort between the San Francisco Department of Public Health (SFDPH) HIV Surveillance section, HIV Prevention section, and the Sexually Transmitted Disease (STD) Prevention and Control Services, the Linkage Integration, Navigation, and Comprehensive Services (LINCS) program has been established to work with persons newly diagnosed with HIV to ensure receipt of test results, to facilitate entry and retention in medical care, and to assist with partner notification services. LINCS receives notification of HIV positive tests from the San Francisco public health and public hospital laboratories for clients testing at SFDPH funded sites. Because persons may have more than one positive antibody test performed, before the LINCS staff begin efforts to locate these individuals,

the HIV Surveillance and Epidemiology section uses eHARS to determine if the test results correspond to a new or to a previously reported person. LINCS and STD control staff employ a variety of methods, including searches of electronic medical records from the clinical care sites of the SFDPH and a professional data aggregating system ("Accurate"), to identify locating information in order to contact and link these individuals to appropriate services. These activities have been developed and implemented as part of the our CDC-funded Program Collaboration and Services Integration (PCSI) plan in which we have expanded data sharing and coordinated activities between HIV, viral hepatitis, STD, and TB programs in SFDPH.

To date, LINCS has been applied to persons newly diagnosed. However, efforts are planned to expand these services to persons who have fallen out of care and whose last known viral load test indicated unsuppressed viremia. Use of eHARS to identify persons who have not engaged with or who have fallen out of care is done using CD4 and viral load tests as surrogate markers of engagement in care. However, this method may over estimate the number of cases not in care because of the limited ability of eHARS to determine if the absence of laboratory test results is due to lack of care or out migration. To develop effective methods to reengage patients who have fallen out of care, we must know the size of this population, their characteristics, and how they can be reached.

As an initial step in developing interventions for persons whose care has lapsed, the HIV Surveillance and the HIV Prevention sections have created the 'Reengaging Surveillance-identified Viremic Patients (RSVP)' project to evaluate the feasibility of using HIV surveillance data to identify persons with unsuppressed viral load and who have fallen out of care, to re-link them to care, and to identify modifiable barriers to and facilitators of sustained care. To estimate the sample size and number of staff needed for these activities, we used eHARS surveillance data

from 2010 and identified 192 patients who had a high viral load in 2010 and had no recorded CD4 or viral load test in 2011. Twenty-seven (14%) patients were known to be deceased as of September 2011. Of the 165 living patients, 111 (67%) were last recorded to be residing in San Francisco; 25 (13%) were known to be homeless. Of these 165 patients , 30% had viral load drawn at the San Francisco General Hospital, a large public safety-net hospital, 13% in a private hospital, 15% in a private provider's office, and 21% had no information regarding the medical facility where the last viral load test was obtained. These findings suggest that information concerning these patients will likely be available within health care settings and as such, the first step in locating these patients will be to contact their last known health care provider. Initial contact to providers will begin in May 2012. Patients who are in need of re-linkage to care will be connected with the LINCS staff.

San Francisco, with its high quality and well-established HIV surveillance system (six years as a MMP site, two years as a PCSI site, and our LINCS and RSVP activities) is well poised to participate in the 'Demonstration Project of Case-Surveillance-Based Sampling for the MMP.' Our highly integrated systems allow us to leverage our experience and ongoing collaboration with other SFDPH sections to test and identify strengths and weaknesses of various sampling methods for MMP activities and to locate and collect information from persons in and out of care. The objectives of the 'Demonstration Project of Case-Surveillance-Based Sampling for the MMP' are in line with the goals and activities of the SFDPH approach to the control and prevention of HIV through early diagnosis and rapid linkage to and support for retention in care.

OBJECTIVES

1. To evaluate the feasibility of sampling patients from eHARS and locating, contacting, and recruiting these patients for participation in an interview and medical chart review.

   Outcome measures:

   i. The number and proportion of selected cases for whom current locating information is available in eHARS.

   ii. The number and proportion of selected cases for whom we have contact information for current health care provider in eHARS or our laboratory database.

   iii. The number and proportion of selected cases for whom we do not have contact information in either eHARS or the laboratory database for whom we identify other contact information using other data sources.

   iv. The number and proportion of sample patients we successfully contact, recruit, interview, and complete medical chart abstractions.

   v. To document facilitators and barriers to achieving the above outcomes.

2. To quantify the number of persons diagnosed with HIV who are in care, never in care, or fell out of care.

   Outcome measures:

   i. The number of persons in care (defined as CD4 or viral load test within six months of eHARS sampling).

ii. The number of persons never in care (defined as no CD4 or viral load, excluding laboratory tests conducted at the time of diagnosis; i.e within one month of diagnosis).

iii. The number of persons no longer in care (defined as having met the definition of in care but no subsequent CD4 or viral load tests for six or more months after last CD4 or viral load test).

3. To characterize persons diagnosed with HIV who are in care, never in care, or fell out of care.

Outcome measures:

i. Measure the distribution of persons in each of the above groups by demographic characteristics.

ii. Measure and describe social determinants of health for persons in each of the above groups.

iii. Measure the number and proportion of persons in each of the above groups who experience disparities in quality and quantity of care.

iv. Measure the number and proportion of persons in each of the above groups who have received recommended HIV-specific medication, vaccination, and screening for STD, tuberculosis, and viral hepatitis.

v. Measure the facilitators and barriers to entry and retention in care.

4. To link or re-link sampled patients into HIV medical care.

a. Outcome measures:

i. The number of persons who met the definition of not in care who are linked to care as evidenced by data in the LINCS database or the

ii. The number of persons who met the definition of having fallen out of care who are re-linked to care as evidenced by data in the LINCS database or the presence of a CD4 or viral load test in eHARS within three months of contact with the patient.

DOCUMENTATION OF ELIGIBILITY

The City and County of San Francisco is not subject to any local or state regulations that would forbid sampling, contacting, and recruiting participants from eHARS. In fact, eHARS is currently used to identify HIV-infected persons for partner services, and to link and re-link persons into care. These activities are considered to be routine public health services and are not subject to local IRB approval.

METHODS

Case Surveillance Data Quality

Procedures to ensure complete reporting of HIV

The success of our HIV prevention and control efforts, including those described above rests on the quality of core HIV surveillance. In San Francisco, approximately 90% of HIV/AIDS cases are reported through active surveillance in which health department staff review the medical records of cases and complete the case report form. This ensures that complete and accurate information is collected. Mandatory reporting of confirmed HIV-positive antibody, and all viral load tests has been in effect since July 2002 and CD4 test reporting has been in effect since September 2008. These electronic and paper-based reports initiate case investigations. Cases are also identified by passive reporting, through review of death

certificates, from validation studies, and from reports from other health departments. We check the California state HIV/AIDS case registry at the time of case or laboratory report and perform the Routine Interstate Duplicative Review (RIDR) every six months to identify and remove any duplicate cases. Cases are updated using reports of CD4 and viral load test results and through medical chart reviews by surveillance staff every 18-24 months to collect laboratory test results, initiation of and changes in HIV treatments, changes in residential address or name, and HIV-related morbidity. Changes in health care providers are also collected when indicated in the medical record. These prospective chart reviews are conducted at all publicly-funded health care sites and at the majority of private health care providers with large HIV practices. To our knowledge, we are the only surveillance jurisdiction that conducts prospective medical chart reviews of reported cases, and these reviews present a unique source of updated clinical and contact information. Deaths are ascertained through monthly review of local vital statistics and through annual matches with the national social security death master file and the National Death Index. Out of the 255 reported deaths in 2009, 146 (57%) occurred in San Francisco.

The San Francisco HIV case registry is assessed regularly for completeness, timeliness and accuracy. Two evaluations of case reporting completeness were conducted in 2011 and both found reporting to be over 99% complete. Ninety-five percent of cases reported in 2010 had a complete case report completed and were entered into eHARS within six months of diagnosis. To ensure the accuracy of the information collected on the case report form, a 10% (or greater) sample of newly reported cases are re-abstracted by a program manager and these data are compared to the originally abstracted data to identify and rectify discrepancies. Errors are brought to the attention of the surveillance staff as part of routine continuous quality assurance. For cases reported by active surveillance from July 1, 2010 through June 30, 2011, errors were

assessed among nine variables collected on the standard HIV/AIDS case report form. The medical chart abstraction error rate of these variables was found to be 4%.

Double data entry is performed on all new HIV/AIDS cases. The data from eHARS and local surveillance databases are assessed for quality assurance on a monthly basis by checking for missing data fields for all required and essential eHARS variables and for inconsistencies. HIV/AIDS San Francisco cases diagnosed in 2010 had 100% completeness for the following variables: state number (stateno), last name soundex, sex at birth, date of birth, vital status, date of AIDS diagnosis and date of HIV diagnosis. Race/ethnicity was over 98% complete.

Follow-up procedures for collecting current patient and provider contact information

Address for all cases is collected at the time of diagnosis and at every prospective medical chart review. A person is reported as homeless at diagnosis if the medical record states that he or she is homeless, if the residence provided corresponds to a homeless shelter, or if the address is not an actual residence (e.g. 'general delivery'). For persons who do not have an address listed or meet our criteria for homeless we record the address as unknown. The current address field in eHARS has been collected on all new case reports since eHARS conversion in August 2009. In addition, during prospective medical chart review, current address is ascertained from the medical record and updated in eHARS. Addresses from cases in HARS were transferred to eHARS at the time of conversion to eHARS. For cases living with HIV/AIDS through the end of 2010, approximately 40% have a current address in eHARS that is different from the address at diagnosis in eHARS, demonstrating the importance of prospective chart reviews in obtaining updated residence information.

Ongoing quality assurance of eHARS contact information

We store case current residential address in eHARS. We perform quality assurance on

this contact information by monitoring the completeness of current address fields (street address, city, state, county, zip code). We also employ ArcView software (ESRI, Redlands, CA) to validate San Francisco zip codes against collected street address information. Again, the ability of the San Francisco surveillance system to conduct ongoing prospective chart review, allows us to continually improve and update the quality and accuracy of eHARS contact information instead on relying only on information collected at time of HIV diagnosis.

Supplementary Laboratory Data

All confirmed HIV-positive antibody, CD4 and viral load test results are reported to SFDPH and imported into eHARS on a monthly basis for all persons tested in San Francisco, including both residents of the city and persons who reside outside of San Francisco but receive care in the city. Approximately 10,000 laboratory reports are processed each month from a total of 29 laboratory companies, of which 17 report electronically. For cases diagnosed with HIV/AIDS in 2010 in San Francisco, 84.3% had a viral load or CD4 test within three months of diagnosis recorded in eHARS. Completeness and timeliness of laboratory reporting is routinely assessed. In 2011, completeness of electronic laboratory reporting at the public health laboratory was 92% and for one laboratory that submits hard copies, completeness was 77%. Among all electronically reported HIV test results from April 1, 2011 through September 30, 2011 the mean time from date of test to reporting to SFDPH was 35.7 days and 68% of lab tests were reported within 14 days. California law mandates that HIV-related laboratory tests be reported to local health officer within 7 days of result.

Laboratory name and facility codes are routinely entered into eHARS. However, because eHARS does not contain fields for the name of the ordering provider, we maintain the Laboratory Data Management System (LDMS), a local laboratory database that contains more

detailed information on HIV antibody, CD4 and viral load tests, including the name and address of the medical provider who ordered the test. Because a laboratory test frequently serves as the initiation of a case investigation, access to the provider who ordered the test is essential. Thus the LDMS allows us to contact health care providers and arrange to review medical records and report cases. This is especially important in San Francisco where at least 30% of cases diagnosed in 2009-2010 had been diagnosed by private providers. The LDMS also serves as an indicator of a change in medical providers which we use when conducting prospective chart reviews. This last point will be critical in our success at locating participants for the MMP case-surveillance-based sampling demonstration project. We anticipate that a large proportion of patients who are in care and sampled from eHARS will be seen for care at private providers, because 60% of 2007-2010 MMP patients sampled for conventional MMP were sampled from private providers.

Contact and Recruitment

Prior to the start of this activity, our local MMP provider and community advisory board members, all local health care providers, the prevention and Ryan White CARE community advisory boards, and HIV community based agencies and partners will be informed of the project rational, objectives, methods, protection of patient privacy, and intended use of the data to address any concerns and to obtain their support. SFDPH has participated in several supplemental surveillance projects and studies, in addition to MMP, that have involved selecting participants from the HIV case registry. Community support for these projects has been positive and we believe, essential to the success of such activities. We anticipate broad support for this demonstration project for several reasons: i) the providers and community have been supportive of MMP, ii) we have an extensive active surveillance system (84% of the most recent laboratory tests from the 961 cases diagnosed from 2009 through 2010 were ordered by medical providers

at our active surveillance sites), iii) we have a fully integrated and active linkage and partner notification service, and iv) we have successfully conducted interview studies that involved sampling patients from the HIV case registry, contacting the provider, and recruiting the patients for interviews [4].

Sample selection will be done using eHARS to sample patients directly or to sample facilities and then create patient lists from which we can select patients. Sampling will be conducted according to procedures developed in collaboration with CDC and participating sites. Prior to sampling patients we will remove deceased cases from the sampling frame. A list of selected patients, the name and address of the health care provider who ordered the most recent laboratory test, and the address of the patient will be created. Recruitment will begin by telephoning the health care provider to verify the patient's address and to assess any perceived barriers to contacting the patient (e.g. mental instability, a known objection to being interviewed [which would likely result in a refusal to participate in MMP], etc.). Patient contact information will be verified or updated at this time. MMP and core surveillance staff is fully integrated and as such eHARS, LDMS, and the SFDPH electronic medical records are readily accessible for MMP staff to obtain contact information for providers and patients.

Contact information for patients who are no longer in care and for whom follow-up contact information is not available from the provider (e.g. patient not known to have moved, provider unaware of patient's address, etc) will be obtained using the methods routinely employed by the STD Prevention and Control Services, LINCS, and RSVP programs for locating individuals. These include the electronic medical records of the municipal STD clinic and all SFDPH hospitals and clinics, client databases for the Ryan White Care program,

homeless shelters, case management, and behavioral health, and "Accurate" a professional data aggregating system.

Using the same methods employed in LINCS, RSVP, and STD partner services programs staff will contact the patient by letter, telephone, or in-person. Staff is well-trained in cultural sensitivity and procedures to ensure that patient privacy and confidentiality are preserved. A standard local protocol for initial and subsequent phone calls and letters to recruit the patient for interview, consistent with those employed by STD control, LINCS, and RSVP, will be developed for this activity. A tracking database will be developed to record the patient names, contact information, the number of attempts to reach the patients, the methods used to contact the patients, and the final outcomes. Recruitment will be done in English or Spanish.

Data Collection: Interview and Medical Record Abstraction

Data collection instruments will be designed in collaboration with CDC and other sites. Medical record abstraction and interviews will be conducted by SFDPH MMP staff who have completed data collection training from CDC. Data collection devices (laptops and PC tablets) will meet CDC and SFDPH security and confidentiality requirements and all data collection staff will be trained to maintain these standards. Data collected will be maintained in the secure HIV surveillance section and securely transmitted to CDC on a regular basis.

Interview

After the patient has been successfully recruited, project staff will schedule an in-person appointment for interview at the SFDPH, an affiliated site or at a place mutually agreed upon where privacy can be assured. San Francisco is geographically small, facilitating in-person interviews. If a face-to-face interview cannot be conducted, a telephone interview will be offered. Telephone interviews may be critical at gaining cooperation with patients that were

diagnosed in San Francisco and have moved away since diagnosis. Staff may travel by public transit or car to locations outside of San Francisco provided they are within two hours travel time to conduct an in-person interview. Interviews will be offered throughout the day including early morning, evening and weekends. When necessary, interviewers bilingual in English and Spanish will conduct interviews in Spanish. Although the number of telephone interview and interviews outside of San Francisco conducted in MMP has been small, we expect that sampling from eHARS will result in a larger number of patients in need of interviews outside of San Francisco or by telephone. As of April 17, 2012, of the 209 interviews completed in the San Francisco 2011 MMP cycle: 12 were telephone interview, 128 were conducted at the SFDPH, 59 were conducted in San Francisco in the patient's home or doctor's office, five were conducted in Spanish and 10 were conducted in-person outside of San Francisco.

The interview session will begin by greeting the patient and then obtaining consent, according to non-research determination and/or local IRB procedures. Oral consent will be obtained by providing the participant with an information sheet that will contain all elements included in standard, IRB approved information sheets even if this activity is conducted under a non-research determination. The interviewer will review the information sheet with the participant to ensure that he or she understands the procedures and provides informed consent. Participants will be compensated $40.00 for interview. A standard local protocol for tracking appointments, scheduling interviews, making appointment reminder phone calls and conducting interviews and interview quality assurance, modeled on our current MMP protocol, will be developed and followed in accordance with SFDPH confidentiality procedures.

Interview staff will complete CDC training. To ensure that interviews are conducted according to protocol and in a culturally sensitive manner, 10% of interviews of all interview

staff will be observed by a supervisor. Results from observed interviews will be provided to the interviewer individually and common problem areas will be discussed with all interviewers.

Medical Record Abstraction

A medical record abstraction (MRA) will be attempted for all selected patients. We will work with the providers who ordered the last CD4 or viral load test or the facility of HIV/AIDS diagnosis to identify medical charts for the medical record abstraction. Procedures on how to select one or more charts for abstraction will be developed in collaboration with CDC and other project areas. While we have been able to complete MRA for 98% of the interviewed patients in previous MMP cycles, we anticipate a lower completion rate when sampling from eHARS because not all sampled patients will be receiving care or receiving care in San Francisco. San Francisco MMP medical record abstractors are integrated with core HIV surveillance and can complete the MRA from our offices using the electronic medical record for all SFDPH clinical sites. All other sites are easily accessible by public transit or on foot.

A standard local protocol for tracking and scheduling MRAs will be modeled after our MMP protocol and followed in accordance with SFDPH confidentiality procedures. A senior abstractor will re-abstract a 10% sample of MRAs and compare results to the original data to identify and correct discrepancies. Staff will be informed of mistakes and when needed, additional training will be provided.

Linkage to Care

This MMP demonstration project will be closely aligned with programmatic activities of LINCS to aid in linkage and re-linkage of HIV-infected persons to care. During the interview, the MMP staff will identify participants in need of referral to medical and ancillary services. As has been our experience with MMP and other interview studies, we anticipate that most

interviews will be conducted at our office. At the end of the interview, participants in need of services will be introduced to a LINCS staff member who will assess the patient's needs, make active referrals to HIV care providers, assist with scheduling of care appointments, and direct persons to community agencies that assist in enrollment into public insurance/benefits and support programs. LINCS staff are conveniently located in our building. When needed or requested, LINCS staff will escort participants to appointments. For participants who are not interviewed in our offices, LINCS staff will contact participants and conduct field visits. The services provided by the LINCS staff are the same whether these are offered in our offices or the field. A protocol for support service referral is already in place and currently conducted as part of the routine MMP interview.

At the end of the demonstration project we will measure the success of our linkage efforts by calculating the number of persons successfully linked to care within three months of contact with LINCS staff by reviewing the tracking database, by computer matching the MMP demonstration pilot sample with the LINCS database, and reviewing eHARS and LDMS for evidence of laboratory test results.

DATA ANALYSIS AND DISSEMINATION

Data from this demonstration project will augment data collected through core surveillance, MMP, incidence surveillance, and behavioral surveillance. None of these surveillance activities provide sufficient information on persons who delay or leave medical care. With the emphasis on diagnosing and treating all HIV-infected persons as a way to both reduce morbidity and mortality and to prevent transmission, linkage to and retention in care is essential. In addition to providing data on persons who are not accessing services, this project will provide important information on the most cost-efficient methods to sample persons in and out of care.

The current MMP sampling method provides a population-based sample but at great expense. Going directly to eHARS offers a method to increase efficiency and reduce costs. As such, participation in this demonstration project will be of great benefit to San Francisco.

Local results from this project will be analyzed and presented to the community advisory boards, included in our HIV/AIDS Epidemiology Annual Report, and, if appropriate, presented at scientific conferences and summarized in one or more peer-reviewed manuscripts. To date, the San Francisco MMP team has been successful in analyzing and disseminating data from MMP and will bring these dissemination skills to this proposed project. We have one MMP manuscript in press in a peer-reviewed journal and have 7 abstracts accepted and/or presented [2, 5-11].

STAFFING

There will be five staff members involved in Demonstration Project of Case-Surveillance-Based Sampling for the Medical Monitoring Project. Two presently work on MMP, two work on Incidence Surveillance, and one Research Associate position is open: Dr. Susan Scheer, the MMP Project Director/Principal Investigator (.10 FTE), Maree Kay Parisi, the MMP Project Coordinator (.10 FTE), Tony Buckman, Incidence Program Coordinator (.20 FTE), Jennie Chin, Incidence Data Manager (.20 FTE), and one open Research Associate position (1.0 FTE). Susan Scheer and Maree Kay Parisi will reduce their efforts on Core Surveillance activities and Tony Buckman and Jennie Chin will reduce their efforts on Incidence Surveillance to work on this project. Susan Scheer and Maree Kay Parisi will serve as key staff on the demonstration project.

Dr. Scheer, the MMP Principal Investigator is also the HIV Epidemiology Section Director and the Principal Investigator for Incidence Surveillance. She will be responsible for ensuring that all aspects of MMP are followed, that the necessary security and confidentiality

standards are met, that all the necessary institutional review board (IRB) approvals or determinations of non-research activity are granted, and for keeping these current throughout the project period. Should IRB approvals and oversight be required, she will communicate any protocol modifications and/or violations to the appropriate IRBs. She will be responsible for ensuring that MMP protocols are adhered to, for all correspondence with CDC and for developing the budget. She will oversee data collection, analysis, interpretation, and disseminating findings. Dr. Scheer has worked on similarly designed project as the MMP demonstration project using eHARS as a sampling frame including the RSVP project.

Dr. Scheer is a member of the PCSI steering committee, and works in collaboration with the STD, TB, HEP C and HIV Prevention sections. She has over 20 years experience conducting and overseeing epidemiologic studies, the majority of which have focused on HIV/AIDS research and surveillance. As Director of the SFDPH HIV Epidemiology Section, which conducts both core surveillance activities and MMP, Dr. Scheer can ensure that core surveillance staff and resources are available to assist in this MMP demonstration project and that these activities will be coordinated and integrated as needed. (see Dr. Scheer's CV in Appendix I).

The MMP Project Coordinator, Maree Kay Parisi, will coordinate both conventional MMP activities and the activities with this demonstration project including monitoring and overseeing participation of MMP sites and sampled patients. She will work be the lead liaison with health care providers to enhance participation. If needed, she will develop and manage Memoranda of Understanding and contracts. She will supervise the Research Associates who conduct chart abstraction and interviews and the core field staff who conduct medical record abstractions for MMP. She will present data to stakeholders and answers questions of prospective providers and participants.

Maree Kay Parisi has worked in some capacity on MMP since 2007, and for the last fourteen months has served as the MMP Project Coordinator. She has worked in HIV surveillance for twenty two years, and has served as the HIV Surveillance Program Director for ten years, giving her expertise in HIV surveillance and with negotiating and setting up MMP with San Francisco medical providers. She assisted San Francisco City Clinic in setting up HIV partner services for newly diagnosed HIV persons seen by San Francisco medical providers, and has integrated core surveillance activities with MMP activities. She is working with the PCSI team to implement the CDC Data Security and Confidentiality Guidelines for Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis programs. (see Ms. Parisi's CV in Appendix I).

Tony Buckman will contact health care providers to obtain or confirm contact information for sampled patients and contact and recruit participants. He will follow a standard protocol for documenting outcomes of his recruitment efforts.

Tony has over 12 years of experience conducting HIV counseling, research and surveillance activities. He worked at San Francisco City Clinic before joining HIV Surveillance in 2004. He became the HIV Incidence Program Manager in 2007 and is responsible for negotiating with sites to participate in incidence surveillance and coordinates incidence surveillance activities with core surveillance staff. He assists MMP staff with recruiting providers and patients. He serves as the lead liaison between the surveillance unit and incidence surveillance activities and assists in HIV/AIDS case reporting.

The HIV Epidemiology Section's Data Manager, Jennie Chin, was recently trained to provide back-up and coverage for the MMP Data Manager. She will assist the MMP Data Manager with processing and managing the MMP sampling frames, interview and abstraction data, patient and facility tracking systems, minimum dataset and SAS coding for analyses. She

will serve as a back-up for the MMP Data Manager for securely transmitting data to the CDC and for communication with CDC regarding data management issues.

Jennie has worked in the HIV Epidemiology Section as a Data Manager for eleven years. She is a proficient SAS programmer and an expert in navigating eHARS. She has written SAS programs and developed procedures for processing electronic laboratory data and for updating eHARS. She has developed protocols and SAS programs that match reported laboratory tests with our local eHARS database to initiate HIV case investigation. Jennie also has experience in managing our local database of deceased HIV/AIDS cases and performs quality assurance and data cleanup on our local case registry and laboratory database.

A Research Associate will be hired as a member of the MMP staff to contact providers and to recruit participants and conduct medical chart abstractions. He or she will participate in any CDC trainings, as well as all local trainings provided to San Francisco MMP staff. He or she will be supervised by Maree Kay Parisi. The Research Associate will be trained in HIV surveillance and confidentiality procedures and core surveillance activities including use of eHARS and the LDMS.

DIVERSITY CRITERIA

Project area name: San Francisco

Project area type: MSA (metropolitan statistical area)

Geographical restriction (state project areas only): not applicable

Research determination for MMP: MMP was initially approved by four local IRBs, two of which have recently granted MMP a non-research determination. Requests to assign a non-research determination to MMP from the remaining two IRBs are pending. San Francisco is considered a surveillance project area.

Complete or near complete laboratory reporting of all CD4 and viral load data in an accessible format: Yes

Interview participation rate in 2010 in relation to mean (55%): The San Francisco 2010 MMP interview participation rate was 55.6%, equal to the mean.

TIMELINE

Project Year 1 (June 1, 2012 – May 31, 2013):

June 2012	Begin development of protocol and data collection instruments.
September 2012	Begin exploratory analysis of eHARS variables and sampling procedures.
November 2012	Finalization of data collection instruments and sampling protocol.
January 2013	Begin sampling (either facility sampling from eHARS or patient sampling from eHARS). If facility sampling from eHARS, recruit selected facilities.
February 2013	If facility sampling from eHARS, construct and submit patient lists from providers. If patients sampled directly from eHARS, contact providers where patients were seen and gain cooperation for assistance contacting patients.
March 2013	If facility sampling, patient sample drawn by CDC or contractor. Begin patient recruitment and data collection.

Project Year 2 (June 1, 2013 – May 31, 2014):

June 2013	Continue data collection.
November 2013	Finalize patient interviews.
January 2014	Finalize patient MRAs.
February 2014	Submit final interview and MRA data and patient dispositions to CDC.
March 2014	Begin local and national protocols for implementation of CSBS for MMP.

April 2014	Begin data analysis and writing of reports and manuscripts.
May 2014	Finalize local and national protocols for CSBS implementation for MMP.

ASSURANCE OF CONFIDENTIALITY

HIV and AIDS case surveillance data are currently collected under an Assurance of Confidentiality under Sections 306 and 308(d) of the Public Health Service Act (42 U.S.C. Sections 242k and 242m(d)). Information collected in the surveillance system that would permit identification of any individual or establishment is collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated in the assurance, and will not otherwise be disclosed or released without the consent of the individual or the establishment in accordance with Section 306 and 308(d) of the Public Health Service Act. Since data in this project will be collected as part of routine surveillance, it will be reported to and maintained by CDC in the same manner as current HIV and AIDS surveillance data and, accordingly, is covered by the existing Assurance of Confidentiality.

The data generated through medical chart abstraction and patient interviews will be subject to the same security and confidentiality requirements as HIV surveillance data at state and local sites and at CDC. This includes adherence to CDC guidelines for the security and confidentiality of eHARS data. All project staff are required to undergo security and confidentiality training at beginning of their employment and subsequently on a yearly basis. All current MMP staff and MMP staff hired for this project have been or will be co-trained in HIV core surveillance procedures and therefore will subject to the same security and confidentially standards as core surveillance.

Sampled patients will be assigned a random unique non-identifying identification number for use in data collection and analysis. Patient interview and medical record abstraction files will not contain specific identifiers such as name and address or eHARS identification (stateno and

cityno). Data collection will be performed on encrypted and password protected electronic devices. Lists of eHARS identification numbers linking to study identification and specific identifiers (the patient's name) will be strictly limited, will not be stored with the MRAs or completed questionnaires and the link will be destroyed once it is no longer needed.

Signed interview information and informed consent forms for the project will be securely stored separately from the completed questionnaires in a secured area in the HIV/AIDS surveillance registry which is accessible only by surveillance staff with secure key codes and is protected by an alarm system with motion detectors. All electronic and paper data and data collection instruments (laptops and PC tablets) will be maintained in locked file cabinets, in a locked file rooms within a limited access area.

Data analysis will be performed using procedures that meet security and confidentiality requirements. Data analysis will be conducted only on-site, in the secure HIV surveillance area using data files without patient name or address. Furthermore, data files for analysis purposes will be stored on encrypted and password protected external hard-drives kept in the HIV/AIDS surveillance registry. Any copies of data that are used on desktop computers for analysis will be destroyed at the end of the work day using PGP software. Data will be presented only in aggregate and demographic characteristics of small cell counts (<5 persons) will not be presented to protect the identity of project participants.

PROTECTION OF HUMAN SUBJECTS

In 2012, University of California Committee for Human Research (UCSF CHR) determined the Medical Monitoring Project should be classified as a non-research public health surveillance project. As such, MMP will no longer be subject to UCSF IRB review and research requirements, and instead can be conducted as part of HIV surveillance for UCSF and SFVA

participants. Two additional sampled facilities have their own IRB and have determined that the Medical Monitoring Project is public health research. The Project Director is working with these two IRBs and has submitted a formal request that MMP be reclassified as a non-research, public health surveillance project. These requests are pending. Until these the reclassifications are approved, the Project Director will continue to submit the MMP protocol for approval and renewal and to represent, as necessary, the project to at their IRB meetings. She also coordinates with these IRBs to ensure that all MMP staff has completed the necessary training for study staff.

Notice of Award

COOPERATIVE AGREEMENTS **Issue Date:** 06/28/2012
Department of Health and Human Services
Centers for Disease Control and Prevention
NATIONAL CENTER FOR HIV, VIRAL HEPATITIS, STDS AND TB PREVENTION

Grant Number: 3U62PS001600-04S1

Principal Investigator(s):
SUSAN SCHEER, PHD

Project Title: PS09-937 MEDICAL MONITORING PROJECT (MMP)

SAJID SHAIKH
DIRIECTOR- BUDGET & FINANCE
SAN FRANCISCO PUB HLTH, AIDS OFC
25 VAN NESS AVE, SUITE 500
SAN FRANCISCO, CA 94102

Award e-mailed to: barbara.garcia@sfdph.org

Budget Period: 06/01/2012 – 05/31/2013
Project Period: 06/01/2009 – 05/31/2014

Dear Business Official:

The Centers for Disease Control and Prevention hereby awards a grant in the amount of $196,104 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH in support of the above referenced project. This award is pursuant to the authority of 307,317K2 PHSA,42USC241,247BK2,PL108 and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact the individual(s) referenced in Section IV.

Sincerely yours,

Merlin Williams
Grants Management Officer
Centers for Disease Control and Prevention

Additional information follows

SECTION I – AWARD D \ – 3U62PS001600-04S1

Award Calculation (U.S. Dollars)

Salaries and Wages	$47,490
Fringe Benefits	$19,946
Personnel Costs (Subtotal)	$67,436
Travel Costs	$5,468
Consortium/Contractual Cost	$111,403
Federal Direct Costs	$184,307
Federal F&A Costs	$11,797
Approved Budget	$196,104
Federal Share	$196,104
TOTAL FEDERAL AWARD AMOUNT	$196,104
AMOUNT OF THIS ACTION (FEDERAL SHARE)	$196,104

Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

05 $0

Fiscal Information:

CFDA Number:	93.944
EIN:	1946000417A8
Document Number:	UPS001600A

IC	*CAN*	*2012*
PS	921ZKDE	$196,104

SUMMARY TOTAL FEDERAL AWARD AMOUNT YEAR (4)	
GRANT NUMBER	**TOTAL FEDERAL AWARD AMOUNT**
3U62PS001600-04S1	$196,104
5U62PS001600-04	$385,194
TOTAL	**$581,298**

SUMMARY TOTALS FOR ALL YEARS		
YR	**THIS AWARD**	**CUMULATIVE TOTALS**
4	$196,104	$581,298
5	$0	$401,770

Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project

CDC Administrative Data:
PCC: N / **OC**: 4141 / **Processed**: WILLIAMSM0 06/28/2012

SECTION II – PAYMENT/HOTLINE INFORMATION – 3U62PS001600-04S1

For payment information see Payment Information section in Additional Terms and Conditions.

INSPECTOR GENERAL: The HHS Office Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1-800-447-8477]) for receiving information concerning fraud, waste or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington DC 20201. Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous. This note replaces the Inspector General contact information cited in previous notice of award.

SECTION III – TERMS A CONDITIONS – 3U62PS001600-04S1

This award is based on the application submitted to, and as approved by, CDC on the above-titled project and is subject to the terms and conditions incorporated either directly or by reference in the following:

a. The grant program legislation and program regulation cited in this Notice of Award.
b. The restrictions on the expenditure of federal funds in appropriations acts to the extent those restrictions are pertinent to the award.
c. 45 CFR Part 74 or 45 CFR Part 92 as applicable.
d. The HS Grants Policy Statement, including addenda in effect as of the beginning date of the budget period.
e. This award notice, INCLUDING THE TERMS AND CONDITIONS CITED BELOW.

Treatment of Program Income:
Additional Costs

SECTION IV – PS Special Terms and Conditions – 3U62PS001600-04S1

Funding Opportunity Announcement Number (FOA): PS09-9370401SUPP12
Award Number: 3U62PS001600-04, Amendment 1

ADDITIONAL TERMS AND CONDITIONS OF THIS AWARD

NOTE 1. INCORPORATION: Funding Opportunity Announcement Number PS09-9370401SUPP12 entitled, Medical Monitoring Project (MMP) are made a part of this award by reference.

NOTE 2. This Supplement to the referenced grant, awards supplemental funds in the amount of $196,104.00 for activities described in your application dated April 23, 2012, for Medical Monitoring Project (MMP).

NOTE 3. These funds are approved for the current fiscal year budget period only. The supplemental activities have a 24 months project period of July 1, 2012 through June 30, 2014.

NOTE 4. REVISED BUDGET SPECIAL CONDITION:

Grantee must submit a revised SF424A form and revised budget narrative justification for the Medical Monitoring Project (MMP) Supplement by July 15, 2012. Failure to submit the required information in a timely manner may adversely affect the funding of this project.

NOTE 5. REPORTING REQUIREMENT: Activities supported by supplemental funding must comply with the Reporting Requirements as referenced in the terms and conditions of the original Notice of Grant Award (NOA) and FOA: PS09-937. These requirements should be reported in your FY 2012 and FY2013 budget periods. CDC/PGO require only ONE Federal Financial Report(FFR) or Financial Status Report (FSR), reporting base funding and supplemental funding for each budget period, due 90 days after the end of the budget period.

NOTE 6. All the other terms and conditions issued with the original award remain in effect throughout the budget period unless otherwise changed, in writing, by the Grants Management Officer.

STAFF CONTACTS
Grants Management Specialist: Kang W Lee
Centers for Disease Control and Prevention (CDC)
Procurement and Grants Office
2920 Brandywine Road, MS E-15
Atlanta, GA 30341
Email: klee@cdc.gov **Phone**: (770) 488-2853 **Fax**: 770-488-2868

Grants Management Officer: Merlin Williams
Center for Disease Control and Prevention (CDC)

Procurment and Grants C e
2920 Brandywine Road, M E-15
Atlanta, GA 30341
Email: mqw6@cdc.gov **Phone**: (770) 488-2851 **Fax**: (770) 488-2868

SPREADSHEET SUMMARY
GRANT NUMBER: 3U62PS001600-04S1

INSTITUTION: SAN FRANCISCO DEPT OF PUBLIC HEALTH

Budget	***Year 4***	***Year 5***
Salaries and Wages	$47,490	
Fringe Benefits	$19,946	
Personnel Costs (Subtotal)	$67,436	
Travel Costs	$5,468	
Consortium/Contractual Cost	$111,403	
TOTAL FEDERAL DC	$184,307	
TOTAL FEDERAL F&A	$11,797	
TOTAL COST	$196,104	$0

File No. 121072

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s): San Francisco Board of Supervisors	City elective office(s) held: Members, SF Board of Supervisors

Contractor Information *(Please print clearly.)*	
Name of contractor: Public Health Foundation Enterprises, Inc.	
Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary. 1. see attached 2. Mark J. Bertler, President/CEO 3. N/A 4. N/A 5. N/A	
Contractor address: 12801 Crossroads Parkway South, suite 200, City of Industry, CA 91746	
Date that contract was approved:	Amount of contract: $111,403
Describe the nature of the contract that was approved: HIV Prevention	
Comments: PHFE is a 501 (c) 3 Nonprofit with a Board of Directors	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

X a board on which the City elective officer(s) serves San Francisco Board of Supervisors
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____
Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer: Angela Calvillo, Clerk of the SF Board of Supervisors	Contact telephone number: (415) 554-5184
Address: City Hall, Room 244 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102	E-mail: Board.of.Supervisors@sfgov.org

Signature of City Elective Officer (if submitted by City elective officer) — Date Signed

Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) — Date Signed

Public Health Foundation Enterprise

Board of Directors:

Bruce Y. Lai (chair)
Peter Jacobson
Teri A. Burley
Karen L. Angel
Michael Ascher
Loretta Davis
Susan DeSanti
Scott Filer
Gerald D. Jensen
Patrick M. Libbey
Erik D. Ramanathan
Edward Yip

Mark J. Bertler, CEO

Print Form

Introduction Form

By a Member of the Board of Supervisors or the Mayor

Time stamp
or meeting date

I hereby submit the following item for introduction (select only one):

☑ 1. For reference to Committee: _____

An ordinance, resolution, motion, or charter amendment.

☐ 2. Request for next printed agenda without reference to Committee.

☐ 3. Request for hearing on a subject matter at Committee: _____

☐ 4. Request for letter beginning "Supervisor _____ inquires"

☐ 5. City Attorney request.

☐ 6. Call File No. _____ from Committee.

☐ 7. Budget Analyst request (attach written motion).

☐ 8. Substitute Legislation File No. _____

☐ 9. Request for Closed Session (attach written motion).

☐ 10. Board to Sit as A Committee of the Whole.

☐ 11. Question(s) submitted for Mayoral Appearance before the BOS on _____

Please check the appropriate boxes. The proposed legislation should be forwarded to the following:

☐ Small Business Commission ☐ Youth Commission ☐ Ethics Commission

☐ Planning Commission ☐ Building Inspection Commission

Note: For the Imperative Agenda (a resolution not on the printed agenda), use a different form.

Sponsor(s):

Supervisor Wiener

Subject:

Accept and Expend Grant – Medical Monitoring Project - $196,104

The text is listed below or attached:

Resolution authorizing the San Francisco Department of Public Health to retroactively accept and expend a grant in the amount of $196,104 from Centers for Disease Control and Prevention to participate in a program entitled Medical Monitoring Project for the period of June 1, 2012, through May 31, 2013. .

Signature of Sponsoring Supervisor: _____

For Clerk's Use Only:

121072

1269