Funding Opportunity Announcement (FOA)
PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments

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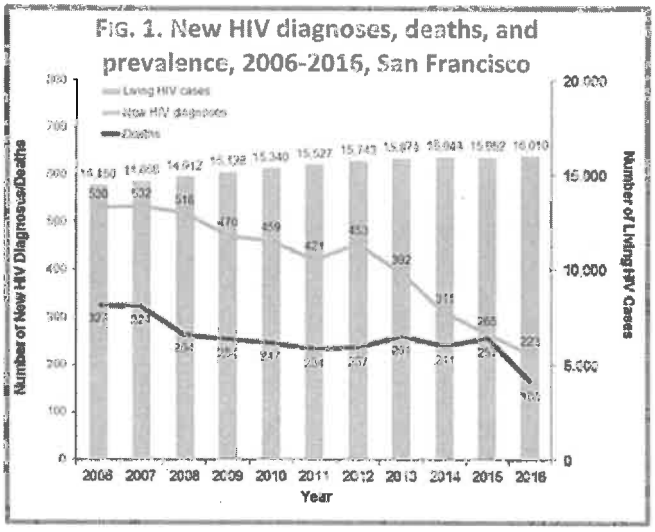
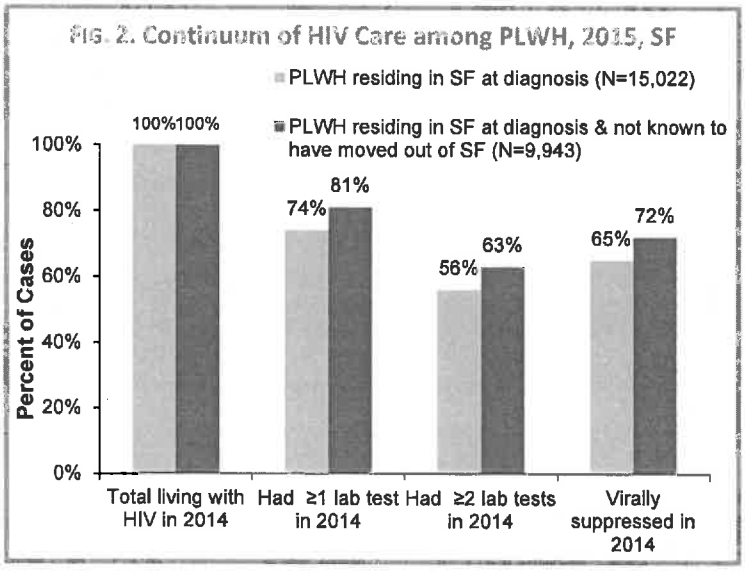
COMPONENT A NARRATIVE

A. BACKGROUND

Over the past 7 years, San Francisco's **rich** network of community-based and clinical providers, in collaboration with the **San Francisco Department of Public Health (SFDPH), have embraced a data-driven high impact prevention (HIP) strategy.** With scaled up testing, early and widespread treatment, a strong linkage to care program, syringe and condom access, and more recently PrEP, San Francisco (SF) cut new HIV diagnoses in half, from 459 in 2010 to 223 in 2016 (FIG. 1).[1]



Inspired by such dramatic progress, in 2013 SF launched the "Getting to Zero (GTZ) SF" initiative[2] with the goals of **zero new HIV infections, zero HIV-related deaths,** and **zero HIV-related stigma and discrimination.** SF has made substantial progress toward these goals and has improved each step along the HIV care continuum (FIG. 2). However, there is still much work to be done. Surveillance data shows **significant disparities in linkage, retention, and viral suppression among people living with HIV (PLWH).**[1,3] African-Americans and Latinos, trans and cis-gender women, people who inject drugs (PWID), and people experiencing homelessness are less likely to be virally suppressed. In terms of new diagnoses, white men who have sex with men (MSM) have benefited the most from the current HIP efforts. Even though most new infections continue to occur among white MSM, people of color make up an increasingly higher percentage of new diagnoses.



In summary, the epidemiologic landscape of HIV in SF in 2017 is significantly different than 2010, calling for a shift in how we implement HIP. This shift will require a **seamless integration of data and programmatic activities** and **multidisciplinary collaborations** with local stakeholders in order to move us further toward our goal of zero new HIV infections. Broad stakeholder engagement with HIV prevention providers, the integrated HIV Community Planning Council (HCPC), and SFDPH staff conducted in preparation for this application revealed a unified vision about how to move forward, embodied in the following **five guiding**

principles: 1) Analyze and develop strategies to address **disparities**; 2) Address the underlying **social determinants of health** contributing to these disparities; 3) Implement **HIV prevention with (not "to") people of color** that involves broad-based community education, empowerment, and mobilization; 4) Mitigate the impact of **HIV-related stigma** on new HIV infections and health outcomes for PLWH; and 5) Focus on the most **vulnerable populations** (both HIV-negative and PLWH) who are not effectively served by the current approach, including people experiencing homelessness, substance use, mental illness, trauma, incarceration, or some combination of those factors (FIG. 3).

FIG. 3. Five Guiding Principles for SF's HIP Strategy, 2018-2022

SFDPH's **Component A** proposal expands on our **commitment to fully integrate surveillance and prevention programs.** It supports strategies that have contributed to the dramatically decreasing HIV incidence in recent years, and implements shifts needed to align with the current epidemiology, including a much stronger equity focus. SFDPH's **Component B** proposal describes *Project OPT-IN* (Opt in for Outreach, Prevention and Treatment) – an innovative, broadly collaborative project serving those whose lives are deeply affected by the social determinants of health (i.e., the vulnerable populations identified in Guiding Principle 5). We must do a better job with these groups if we hope to "get to zero," for all SF populations.

B. APPROACH

i. Purpose

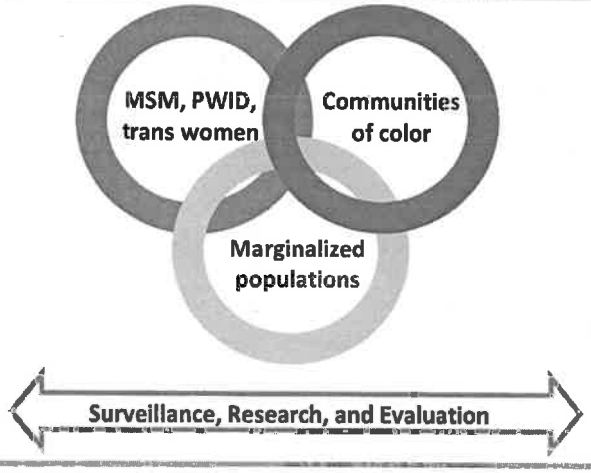
SF's integrated prevention and surveillance program (FIG. 4) will maintain its strong emphasis on HIP for high prevalence populations (MSM, PWID, trans women), while bringing an increased focus to the prevention needs in communities of color and the HIV-related disparities they experience in new infections, late diagnoses, linkage, retention, and viral suppression. If funded for Component B, SF will be able to fully embrace the comprehensive strategy needed to "get to zero" by strengthening services and systems for the most marginalized populations living with and at risk for HIV.

FIG. 4. Current and Proposed Focus

Current Focus (2010-present)
HIP for high prevalence populations, with some programming for communities of color and marginalized populations

Proposed Focus, Component A
Maintain focus on high prevalence populations, and expand HIP to better address disparities in communities of color

Proposed Focus, Component B
Add innovative programming to better address disparities among marginalized populations



ii. Outcomes

SF proposes to **reduce new HIV infections by 50% by 2022** – and likely more if funded for Component B. Although this is perhaps an overly ambitious goal, we hope to inspire the HIV community to come together to do everything possible to achieve it. FIG. 5 depicts all SFDPH project period outcomes.

FIG. 5. Project Period Outcomes

CDC Long-term Outcomes	SFDPH Outcomes
Reduced new HIV infections among persons at risk for HIV infections	•Reduce new HIV diagnoses by 50%, from 223 in 2016 to 111 in 2022, as measured by HIV surveillance data
Increased access to care for PLWH	•Increase the proportion of persons newly diagnosed with HIV who are linked to care within 1 month of diagnosis, from 78% in 2015 to 85% by 2022, as measured by HIV surveillance data
Improved health outcomes for PLWH	•Increase the proportion of persons newly diagnosed with HIV who achieve viral suppression within 12 months of diagnosis, from 77% in 2015 to 85% by 2022, as measured by HIV surveillance data
Reduced HIV-related health disparties	•Increase retention in care among populations retained and therefore virally suppressed (cis and trans gender women, people of color, Latinos, PWID and homeless) by 5% by 2022, as measured by HIV surveillance data
Reduced death rate among PLWH	•Reduce the HIV-related death rate among PLWH by 10%, from 15 per 1,000 in 2015 to 13 per 1,000 by 2022, as measured by HIV surveillance data

iii. Strategies and Activities

Strategy 1: Systematically collect, analyze, interpret, and disseminate HIV data

SFDPH will conduct ongoing **core HIV surveillance activities** and **HIV prevention program evaluation** to identify specific populations at risk for HIV and living with undiagnosed HIV. Key HIV care and prevention indicators collected from core surveillance (for example, all steps along the HIV Care Continuum as well as information on late testing) will be analyzed by demographic characteristics to identify populations of concern. The **data will be shared** with clinical and community-based providers and the HCPC, and **HIV prevention strategies will be rapidly adjusted** to align with current trends. The SFDPH HIV surveillance and prevention programs have an established history of collaboration, support and data integration/sharing and dissemination. HIV surveillance data is shared with the LINCS (linkage, integration, navigation, comprehensive services) program to: 1) Ensure *all* patients diagnosed with HIV in San Francisco are offered partner services (PS) and linkage to care; 2) Improve the efficiency of PS activities by providing HIV and viral load data on named partners identified through HIV and syphilis PS; 3) Provide and refine "not-in care" lists and STD patient lists for targeted outreach by LINCS care and PrEP navigators, respectively; and 4) provide names of clinical providers diagnosing HIV and STDs who may benefit from public health detailing activities.

SFDPH has been conducting **Data to Care** (DTC) Activities as a joint activity between HIV surveillance and the LINCS program since 2012 when we conducted the study RSVP: "Re-engaging Surveillance-identified Viremic Patients in Care" [4,5]. Since then our DTC activities have expanded (see Strategy 4 below for more detail), including efforts in the CDC-funded

PrIDE Project focusing on African-American and Latino MSM and trans women. Drawing on this experience, we will be refining and improving our DTC efforts in the next five years and applying lessons learned in DTC to local **Data to PrEP** efforts.

Another unique feature of core surveillance activities at the SFDPH is our completion of a medical chart review on all PLWH in San Francisco every 12 months to document and update variables not collected at time of initial diagnosis. These variables include vital status, use of additional therapeutic and prophylactic treatments, subsequent opportunistic illnesses, most recent address, and additional CD4 and viral load results. This allows us to track key indicators, including evaluating SFDPH and GTZ initiatives such as the same-day ART initiation program, and maintain a **current address for all PLWH**, which is key component to the success of the DTC and LINCS programs. Address information is geocoded to the census tract level. This enables HIV surveillance to produce maps shared in our annual epidemiology report and to our prevention partners that show, for example, the geographic distribution of all PLWH, newly diagnosed cases and their viral suppression and linkage to care rates, as well as testing rates by age and zip code.

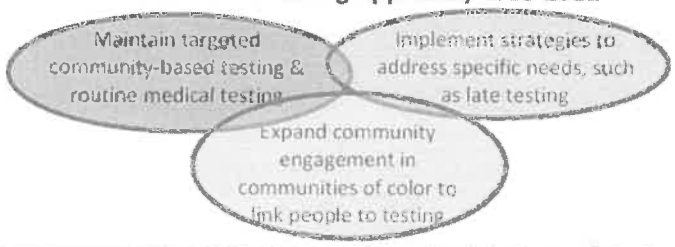
SFDPH will also conduct **HIV prevention program monitoring and evaluation**. Community-based organizations providing HIV testing will enter test-level data into EvaluationWeb by the end of the week following the week in which to test was conducted; test data from medical settings and select community-based test sites will be uploaded monthly.

SFDPH will meet all other CDC data reporting requirements by specified deadlines, including: 1) the final Evaluation and Performance Measurement Plan (by June 30, 2018), 2) the annual performance report by September 30th each year, 3) data on performance measures (at least twice per year); and 4) the final performance and financial report (by March 30, 2022). (For additional information on program evaluation, see *Applicant Evaluation and Performance Measurement Plan*).

Strategy 2: Identify persons with HIV and uninfected persons at risk for HIV[a]

Data from the National HIV Behavioral Surveillance Survey (NHBS) indicates that the proportion of undiagnosed HIV has plummeted to an estimated 7% among all PLWH, and among MSM it is 3% [6]. Much of this success can be attributed to scaling up HIV testing. Starting in 2012 in SF, community-based HIV testing programs helped shift the community norm to embrace HIV testing as part of regular health maintenance, especially for gay men. In addition, primary care and other clinical settings began to adopt routing HIV screening. SFDPH and its CBO providers also rapidly adopt new technologies when and where they make sense, such as RNA testing at sites with high numbers of new diagnoses.

FIG. 6. SFDPH Testing Approach, 2018-2022



The data clearly indicates that the testing strategy has been effective, and that we have been most successful in addressing HIV among MSM, the population most affected by HIV for the last 30

[a] See Strategy 4 for Data to Care activities.

years. However, now with only a few hundred new diagnoses each year, getting to zero new infections for all populations, even those with low incidence, will require new, culturally specific, strategies to reach them. The proportion of undiagnosed HIV infection, for example, varies by population and race. Among all MSM, undiagnosed HIV is estimated to be 3% but among African-American MSM it is 14%, among Latino MSM it is 7%; among trans women it is 5% and among PWID it is 44% [6].

Our approach to testing over the next 5 years will be: 1) keep what has worked; 2) incorporate strategies to achieve wider reach; and 3) implement some highly focused efforts to address specific gaps (FIG. 6). In 2018, HIV Prevention and Surveillance will work closely with community stakeholders such as the HCPC, CBOs, clinics, and the GTZ Consortium, bringing together data and community wisdom, to determine how best to implement these shifts.

1) SFDPH will maintain:

- High-volume community-based **targeted testing** (including SFDPH City Clinic) for MSM, PWID, and trans women, incorporating the latest testing technologies as appropriate;
- **Integrated testing** (where possible and where it makes sense, depending on resources and data), including chlamydia, gonorrhea, syphilis, hepatitis B and C, and tuberculosis;
- Testing of **partners of HIV-positive** individuals through the LINCS PS program;
- **Routine opt-out screening** in SFDPH clinical settings;
- Routine **perinatal screening;** and
- **Accessible, high quality laboratory-based HIV testing and case reporting.** SFDPH will continue to work with laboratories to ensure timely and accurate reporting, as required by Title 17 of the California Health and Safety Code. In addition, SFDPH's Public Health Laboratory is supported with Component A funding and is a solid partner.

2) SFDPH will "cast a wider net" to a) address disparities in new infections among African Americans and Latinos, and b) find cases in low incidence populations (such as women). This does not mean testing anyone and everyone, which would not be high impact. In communities of color, especially Black communities, culturally relevant communication and engagement strategies that address the whole community are needed to reach the small percentage of people at risk and link them to HIV testing. SFDPH will enhance its current efforts as follows:

- Implement **culturally specific community engagement and mobilization** with communities of color (see Strategy 7 for more detail) and link people to testing as appropriate;
- Further normalize and de-stigmatize HIV and STD testing to reach beyond those who traditionally test, by **continuing to expand medically based HIV opt out testing** with 3rd party reimbursement (both within and outside of SFDPH); and
- Explore opportunities to **expand integrated approaches to sexual health services** in novel settings (such as HIV/STD screening and PrEP delivery at pharmacies).

3) SFDPH will adopt highly focused strategies to address **very specific gaps**:

- SFDPH will conduct a deep exploration into the characteristics of newly infected individuals and the circumstances surrounding their HIV acquisition, by conducting interviews (modeled on a shortened Medical Monitoring Project interview) at diagnosis. The data will help us understand and focus on the most **current factors driving new HIV infections.**
- SF continues to have a **high proportion of late testers.** Although the proportion of late testers has declined in recent years, still 16% of people first testing positive for HIV in 2016 developed AIDS within 3 months of initial HIV diagnosis. They are often diagnosed in the

emergency department or urgent care after already having been there at least once without being tested. SFDPH will use **public health detailing** to increase routine testing in these settings, as well as in pharmacies and parole/post-release programs.

- **Undiagnosed HIV among PWID** is estimated at 44% in NHBS [7] and we will pilot new and innovative testing strategies for this population.
- We will explore network testing for **"high-high" risk groups** (e.g., MSM sex clubs).
- To address rising STD rates among MSM in the era of PrEP, SFDPH will ensure an **increased focus on sexual health and STDs** in funded community-based testing programs, and will use public health detailing with primary care providers to increase their skills.

Partner Services (PS) is a critical intervention that allows SFDPH to efficiently identify, test and treat sexually active, at-risk individuals in order to keep them healthy and prevent transmission of HIV and syphilis to their partners. Our LINCS team consists of specialized disease investigators based at City Clinic and public health clinics in SF, who offer PS and linkage to care services to **all** newly diagnosed patients and re-linkage services to PLWH who have fallen out of care. These activities are conducted in collaboration with HIV Surveillance. Data from surveillance is used to identify all newly diagnosed persons (at private and public medical or testing sites) for PS outreach. Named partners are routinely offered testing and PrEP services (if HIV-negative) or HIV navigation (if HIV-positive and not-in-care). Surveillance data is used to determine the HIV serostatus of named partners and who is eligible for HIV navigation. We will **expand PS to include provision of HIV preventive services to sexual and needle-sharing partners of HIV-positive not in care (NIC) individuals** identified through LINCS navigation. LINCS PS will continue to use STD/HIV surveillance data (including network transmission analysis) to maximize the number of persons identified for PS. In addition, by working directly with sexually active patients, LINCS staff can often identify missed opportunities for HIV prevention services (e.g. PrEP, PEP, STD or HIV testing) and connect clinical providers to SFDPH's existing public health detailing program, which provides education on specific HIV prevention topics and strategies to clinicians. Information collected through PS activities, including current contact information and HIV testing history, is routinely fed back to HIV surveillance and updated in eHARS.

Strategy 3: Maintain HIV transmission cluster/outbreak response plan

As a currently CDC-funded HIV Molecular Surveillance site, SFDPH has established program capacity for cluster detection. We have exceeded CDC performance standards for HIV sequence data collection and use this data for analysis of transmitted drug resistance in SF [8]. In addition to continuing to cooperate in the investigation of multi-jurisdictional transmission clusters identified at the national level by CDC, we will implement Secure HIV-TRACE to identify local transmission clusters. Investigation of transmission clusters will identify risk networks of concern, including those with recent ongoing transmission, persons with poor outcomes such as unsuppressed viral loads, vulnerable populations such as PWID, persons with drug-resistance strains of HIV, or persons with Stage 0 HIV infection. In the event of a cluster or outbreak, HIV Surveillance and LINCS would partner to rapidly locate and link people in the cluster to care, and provide testing and linkage to named partners.

Strategy 4: Provide comprehensive HIV-related prevention services for diagnosed PLWH

Implemented in 2011, SFDPH's model LINCS program provides linkage to care for people newly diagnosed with HIV, patient navigation for PLWH not-in-care (NIC), and partner

services, with the goal of linking to clinical care within 5 days of diagnosis. Surveillance and LINCS share data to ensure that **all persons newly diagnosed in SF receive PS and linkage to care assistance at time of diagnosis,** including ~50% who are diagnosed in private medical settings. LINCS also works closely with the PHAST team (Positive Health Access to Services and Treatment) at the Zuckerberg SF General Hospital to coordinate rapid linkage to HIV care and the initiation of antiretroviral therapy (ART) for patients diagnosed there.

Surveillance data has shown substantial improvement in initial linkage to care and ART initiation among persons newly diagnosed with HIV (median time from diagnosis to first care visit is just 7 days and time from first care to ART initiation has decreased from 30 days in 2012 to just 6 days in 2015). The RAPID Initiative, funded through the SF Getting to Zero initiative, has facilitated these substantial improvements by 1) providing public health detailing to providers about rapid linkage and ART initiation; 2) working with clinics to adapt workflows and develop protocols so that newly diagnosed patients can be offered a first care appointment within 5 days of diagnosis; and 3) developing and disseminating lists of "rapid" sites to CBOs, HIV test counselors and the LINCS team. SFDPH will continue the LINCS, PHAST, and RAPID efforts that have contributed to these improvements. Retention in care, however, remains a substantial challenge. Retention in care has remained steady, ranging from 63% and 68% in recent years, largely due to care barriers created by substance use, mental illness, homelessness, and trauma. Therefore, our approach in next 5 years is to **strengthen the existing continuum of retention services (FIG. 7),** and establish systems to identify markers of risk for falling out of care to allow **earlier intervention and differentiated care services,** before a person is lost to care. In essence, we will move towards reframing the concept of retention to "preventing people from falling out of care," developing corresponding indicators for assessing who is at risk for falling out of care and targeted services to prevent care attrition.

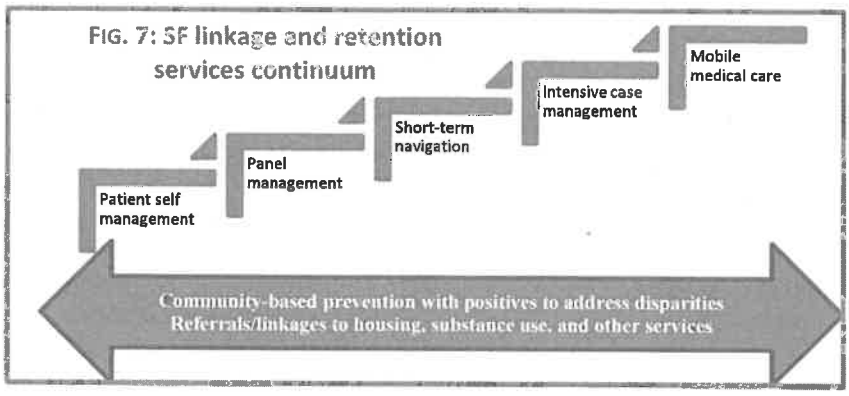


FIG. 7: SF linkage and retention services continuum

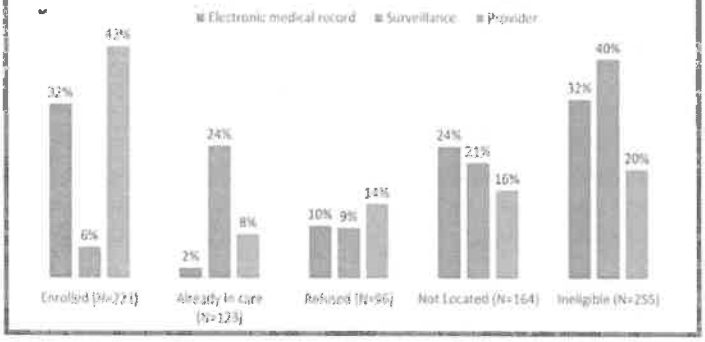
Our integrated HIV prevention and surveillance program, using core surveillance and other data as well as community input, will design and implement specific community-based, clinical, and DTC strategies to improve retention. For retention, as for linkage, our key team is LINCS. In 2015-2017, among patients enrolled in LINCS navigation, 95% were re-linked to care as confirmed by surveillance data. Much of the success of the LINCS program is attributed to established relationships and streamlined communication with clinical providers in the public health clinics on which we will continue to build. In 2017, funded through the SF Getting to Zero initiative, community-based intensive case management services have been added to the retention service continuum, to take referrals from LINCS for people who need significant ongoing support to remain engaged in care.

Additional community-based and clinical strategies will include developing and implementing a protocol for retention planning with patients at initial diagnosis, increasing collaboration between

the SFDPH's Population Health Division and the San Francisco Health Network to increase HIV retention panel management within SFHN, and aligning/leveraging Ryan White services with the model in FIG 7. Lastly, SFDPH will continue to support evidence-based prevention with positives programs focused on reaching and supporting communities with the greatest retention disparities. These programs will be peer-based and work closely with and get referrals from partners across the retention continuum. In addition to these community-based and clinical efforts, SFDPH has a robust and nuanced DTC program, which is a collaborative effort between Surveillance and LINCS. LINCS was first developed in 2011 to re-link NIC patients and has since expanded to receive NIC patient referrals from three sources: 1) clinical providers, 2) a query of the SFDPH electronic medical record (EMR) cross-matched with surveillance to remove patients who were already in care or who had migrated out of SF, and 3) a surveillance-generated list.

In order to better understand the effectiveness of referral strategies and better target LINCS resources, we compared navigation and linkage outcomes of NIC patients identified by these sources [9] (FIG. 8). Provider identified referrals were the most effective in terms of navigation enrollment (42%), and included only a small percentage of people who were already in care (8%). In contrast, nearly a quarter (24%) of the surveillance-generated referrals were already in care when investigated.

FIG 8. Provider-identified referrals were most likely to be located and enrolled in LINCS navigation



Results from this evaluation will be used to shift how we use surveillance-only generated lists. Although not as effective as other combination DTC strategies, surveillance-generated lists may still be effective at identifying populations that have the greatest disparities in retention, such as MSM of color and trans women. Additionally, surveillance-generated lists are the only way to identify persons living with HIV that have never accessed HIV care. Given the disparities in linkage and suppression rates in the first 12 months after diagnosis[1], we will intensify efforts to ensure that all patients who are not linked to care within one month of diagnosis or who are not virally suppressed by 12 months after diagnosis are offered LINCS navigation services.

Strategy 5: Provide comprehensive HIV prevention services for HIV-negative persons

Over the past 2 years, SFDPH and Getting to Zero have collaborated to rapidly roll out a **comprehensive PrEP strategy** that builds upon our existing HIV infrastructure, while also piloting innovative models for PrEP access, such as Data to PrEP and pharmacy-delivered PrEP. The current strategy, which is exclusively funded through sources other than this FOA, is detailed in FIG. 9. Through these programs, people can receive eligibility screening, linkage to and support for PrEP, and adherence support. Social marketing and community engagement are aimed at increasing consumer knowledge, access, and use, while the public health detailing effort is directed at enhancing provider knowledge and support for PrEP. To date, PrEP roll out has been a huge success. Programs have evolved rapidly to meet community needs and PrEP uptake is generally high among MSM [7,10]. SFDPH's priority for 2018 is to evaluate these very new

programs and initiatives, and make data-informed decisions about what to integrate into our ongoing core HIV prevention strategy once CDC Project PrIDE funding ends.

In addition, SFDPH will increase the impact of our current PrEP strategies and interventions by:

- Reducing the time from when a person wants to start PrEP to first dose (anecdotally, a number of people have seroconverted during this period), by increasing access to same-day PrEP;
- Facilitating connections between PrEP programs to ensure no one is on a waiting list;
- Utilizing California's PrEP Drug Assistance Program (PrEP DAP) when it becomes available;
- Increasing collaboration with the school district, its CDC Division of Adolescent and School Health (DASH)-funded program, and local colleges and universities to open additional access points for young MSM and trans female students;
- Incorporating PEP into all PrEP discussions, so that clients who choose not to start PrEP know how to access PEP;
- Closely monitoring PrEP access for young MSM, trans women, and PWID, who have particular challenges related to insurance and stability, and make adjustments in our strategies as needed;
- Continuing to learn from communities about their unique barriers and support and work with community members to develop and disseminate culturally appropriate messaging to address misinformation and remove roadblocks to PrEP access;

FIG. 9: SFDPH PrEP Strategy

PrEP in Clinical Settings

- City Clinic PrEP program
- SFHN Primary Care/W86 PrEP program
- Mission Wellness Pharmacy-based PrEP
- Linkage to PrEP for HIV-negative partners identified through Partner Services

PrEP in Community-Based Settings

- PrEP navigation services
- PrEP community engagement, linkage to PrEP, and PrEP maintenance/adherence support for communities with disparities in PrEP uptake (trans women, Latino MSM, young MSM, Black MSM)

Community-Level PrEP Intervention

- Our Sexual Revolution
- #AskaboutPrEP
- PrEP/condom campaign
- PrEP ambassadors/peer leaders
- PrEP town halls
- Community outreach at fairs and festivals

Provider & Systems Capacity-Building

- Public health detailing
- Citywide PrEP navigators group
- Training for HIV test counselors on PrEP referrals and linkage
- Citywide PrEP training and technical assistance
- GTZ PrEP Providers Subcommittee

Pilot Projects

- Data to PrEP
- Text messaging campaign to increase knowledge and improve access
- Emergency Truvada for youth

- Strengthening panel management systems for PrEP programs at City Clinic, the SFHN and CBOs to identify patients on PrEP who are lost to follow-up or have discontinued PrEP due to changes in insurance status, so there is no interruption in PrEP;
- Scaling up a pharmacist-delivered PrEP program at a community based pharmacy in the Mission district serving Latino clients;
- Ensuring that PrEP services and materials are available in Spanish;
- Integrating PrEP education for PLWH into Ryan White services and other services for PLWH, including PrEP referrals for their partners.

In addition to PrEP, SFDPH will support **community-based health education/risk reduction services** that aim to reduce the impact of substance use and other drivers on HIV acquisition, educate and link people to PrEP and testing, and link people to other needed resources and services, such as housing, mental health, and substance use. In 2018, SFDPH will work with the

HCPC and community-based HIV prevention providers to solicit input on these services, and their ideas will be incorporated into the community-based HIV prevention RFP.

Strategy 6: Conduct perinatal HIV prevention and surveillance activities

SFDPH has not had a case of perinatal HIV since 2005 and therefore will continue its current successful strategy of perinatal HIV prevention – supporting routine testing of pregnant women and collaborating with the UCSF HIVE Program (see HIVE letter of support). In addition to providing direct services, including pre-conception and prenatal services for women living with HIV and women with HIV-positive partners as well as PrEP for women at risk, the HIVE Program works to build and sustain capacity throughout San Francisco for perinatal prevention. HIVE **promotes routine perinatal HIV testing** of all pregnant women per CDC recommendations, operates a perinatal HIV hotline for clinicians, trains clinical providers and frontline workers, integrates perinatal prevention activities into methadone clinics and homeless outreach, and targets capacity-building for PrEP and prevention interventions to clinics where women are diagnosed with HIV.

SFDPH will continue its routine case surveillance including women diagnosed with HIV and their infants if meeting HIV case definition. Data on women with HIV and perinatal HIV are included in the annual surveillance report. In addition, HIV surveillance matches the HIVE patient registry of HIV-positive women to the surveillance registry to determine sustained viral suppression among HIV-positive post-partum women to assist HIVE with outreach to women who fall out of care after delivery. SFDPH requests to opt out of Perinatal HIV Exposure Reporting and Fetal Infant Mortality Review because of the absence of a perinatal and pediatric HIV case in over 12 years.

Strategy 7: Conduct community-level HIV prevention activities

Social Marketing/Social Media. The overarching themes for social/marketing media efforts will be **raising awareness about PrEP and how to access it, addressing HIV- and PrEP-related stigma, and promoting overall sexual health** (for example by incorporating STD prevention messages into HIV prevention and PrEP campaigns). We will focus on producing messaging and imagery, and using **social media and other communication channels that are tailored to specific populations**. SFDPH will strengthen community engagement in campaign development and messages, to ensure cultural relevance. For example, messages disseminated through Spanish radio might be appropriate for reaching Latinos. Messages that speak more to people's complex racial and cultural identities rather than gay-identity-focused campaigns might be more effective in Black and other communities of color. Effective use of social media for youth (Instagram, Twitter, Snapchat) is also a priority to make HIV testing and PrEP "trendy" and not stigmatized. In general, SFDPH will increase the online presence of sexual health education and risk reduction, incorporating information about PrEP and other emerging developments.

Community Mobilization. Mobilizing communities is critical to the success of all other HIV prevention strategies. There is consensus among SFDPH and our partners that the current approach to HIV prevention has essentially reached everyone it's going to reach. Our most important job now is to scale up **"risk-blind" broad-based community engagement and mobilization** – fostering community ownership of prevention by respecting and working within communities' own cultures, social systems, institutions, and norms. For the past 7 years, HIV prevention has focused on gay and other MSM, PWID, trans women, and PLWH. This strategy has been enormously successful in reducing new HIV diagnoses, but with over 200 new

diagnoses each year, these approaches have not worked for everyone. It is time to try something new. This shift will not always require additional resources, but rather a shift in thinking and approach.

For example, Black MSM continue to experience disparities across the prevention/care continuum. What we will move toward is: a consistent presence in the Black community to build trust; prevention workers who are peers and live in the community; relationships with community leaders and their networks; dialogue with individuals and families at churches, flea markets, at barbecues –where family and community lives and thrives; and a focus on health and wellness and meeting the needs articulated by the community (not the health department), rather than a singular focus on HIV. Black MSM have the triple stigma of being a sexual minority, being affected by HIV, and being a person of color. Some may have been disowned by their families of origin, yet are unable to find a family of choice within the gay community due to racism. Prevention efforts need to fully embrace and work within the reality of Black community members' lived experience and reach all Black MSM including those for whom mainstream, gay-focused HIV messaging does not resonate and for whom services designed for gay men do not feel welcoming. SFDPH and community providers will **integrate this ground-up community-centered approach into all of our work.**

Syringe access and disposal. **Syringe programs have provided sterile syringes, supplies, and treatment referrals to people who inject drugs (PWID) in San Francisco since 1990.** These programs are widely believed to be responsible for the relatively low HIV prevalence and incidence among PWID and their heterosexual non-PWID sex partners. SFDPH will continue to support syringe access and disposal services and collaboration with CBOs that manage the sites. Currently, there are 12 sites that offer multiple hours and days of coverage, and we are always exploring how to improve access for PWID in parts of the City with less coverage. Through the **Syringe Access Collaborative** (SAC), services are available daily, and 87% of PWID report having accessed free syringes through these programs.[7] In addition to sterile equipment, syringe programs provide active drug users with a safe and welcoming environment to get information, naloxone, referrals to primary care and other services, and linkage to substance use treatment and hepatitis C testing and treatment. Lastly, syringe disposal is an important component of the program and represents our commitment to keeping City streets safe and clean. This includes conducting citywide sweeps and clean-up events, placing outdoor disposal kiosks, and working with neighborhood associations to identify creative solutions for syringe disposal.

Condom access. In San Francisco, access to free condoms is high. **SFDPH and its community partners distributed more than 1.6 million free condoms in 2016**, and NHBS data show that 70% of MSM reported receiving free condoms, over 60% reported using them, and free condoms from HIV organizations increased from 9% to 40% from 2004 to 2011 [7]. To maintain access, SFDPH will continue to support targeted distribution at clubs, bars, clothing stores, DVD rental outlets, leather goods stores, gyms, and other locations frequented by MSM. Additional agencies and venues (healthcare and non-healthcare) not already receiving condoms can place an order to receive free condoms from SFDPH's Condom Distribution Program. SFDPH will expand collaboration with local businesses to bring free condoms to communities with less access. Ryan White and HIV prevention providers will continue to be required to make free condoms available to clients. In addition, Jail Health Services maintains 14 condom dispenser machines across three jail facilities, from which more than 11,000 condoms were distributed in 2016.

San Francisco's biggest challenge with condoms is not access, but use. The changing role of

condoms in HIV prevention is perhaps best exemplified by the change in language – we no longer talk about "unprotected sex" but rather "condom-less sex" – because data shows that sex while on PrEP or ART is essentially protected sex when it comes to HIV transmission. With PrEP uptake and the proliferation of the "undetectable = un-transmittable" message among MSM, there have been concurrent declines in condom use and increases in STD. A recent publication using SF MMP and surveillance data found that HIV-positive MSM reported a higher prevalence of condom-less anal sex with negative partners on PrEP vs. not on PrEP [11]. This phenomenon has created a dilemma: How do we affirm the sexual liberation that PrEP and ART have brought while emphasizing that condoms are still relevant for STD prevention? How can SFDPH promote meaningful messages about condoms without the messages being dismissed as being "out of touch"? SFDPH, the HCPC, and prevention CBOs will grapple with these issues in the coming months.

Strategy 8: Develop partnerships to conduct integrated HIV prevention and care planning

In mid-2016, San Francisco held the first meeting of its integrated prevention and care council - the HIV Community Planning Council (HCPC). The HCPC is currently co-chaired by Jose-Luis Guzman (SFDPH HIV prevention representative), Dean Goodwin (SFDPH HIV care representative) and Community Co-chairs Ben Cabangun, Charles Siron, and Linda Walubengo. SFDPH and the HCPC are close partners in HIV prevention, and we strive to develop a collective vision and shared priorities for HIV prevention. HCPC meetings are a place for open discussion and debate on current challenges in HIV prevention, care and treatment. SFDPH brings both leadership and humility to the Council process, ensuring that the HCPC uses data-driven methods for setting priorities while also listening to the community's lived experience. In addition to the HCPC, SFDPH is part of multiple prevention and care networks – Getting to Zero, HIV/AIDS Provider Network, Citywide PrEP Navigators Group, HIV Frontline Workers Group, HIV Testing Coordinators Group, Transgender Advisory Group, and many others.

The HCPC's first integrated plan was released in late 2016, shortly after the newly formed Council convened. The 2016 plan is the current active plan. Because it was released at the end of 2016, it will not be updated this year; in 2017, the Council will focus on monitoring progress on the priorities. The plan will be updated in 2018 in collaboration with HCPC.

Strategy 9: Implement structural strategies to support HIV surveillance and prevention

SFDPH has a long history of collaboration between HIV surveillance and prevention programs including, for example, sharing data for Partner Services, DTC activities (including working with CBOs and medical clinics) and Data to PrEP. We will continue to improve data sharing and address any barriers in order to further improve the integration of surveillance, program, and clinical data and develop data-driven HIV prevention efforts while protecting patient/client privacy. Our data managers and epidemiologists are cross-trained to work across systems and we will continue to further integrate our databases into one system for HIV and STD surveillance and prevention services. Updated contact information from DTC activities update the HIV surveillance registry. Additionally, we will explore new sources of data, from private sector health systems and pharmacies for example, to facilitate our activities.

Strategy 10: Conduct data-driven planning, monitoring, and evaluation

SFDPH has a long track record of data-driven HIV prevention, working with the community planning group to understand the community context behind the data, and developing a prevention strategy that directly addresses current HIV trends. Epidemiologic data is shared with

the HCPC to inform the Integrated Plan. SFDPH then solicits services and implements community-based and DPH-based programs and SFDPH in collaboration with the HCPC and Getting to Zero evaluates these programs and services, and quality improvement is ongoing based on findings (FIG. 10).

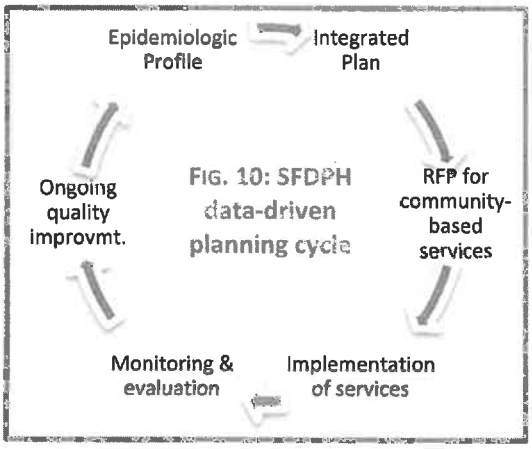


FIG. 10: SFDPH data-driven planning cycle

Strategy 11: Build capacity for HIV program, epidemiology, and geocoding activities

2018 will be an intensive capacity-building year for San Francisco's HIV prevention CBOs. SFDPH will work closely with the HCPC, CBOs, and other stakeholders to plan for shifts in HIV prevention strategies and activities as described in 1-7 above. Capacity-building assistance (CBA) needs will be assessed and CBA plans developed annually thereafter. A new Community-Based HIV Prevention Request for Proposals (RFP) will result in new services in January 2019. SFDPH does not anticipate any epidemiologic CBA needs. Furthermore, HIV surveillance conducts extensive geocoding activities including, for example, mapping new diagnoses, PLWH, and viral suppression.

Collaborations

SFDPH's HIV surveillance and prevention work is distributed primarily across three health department branches: 1) Applied Research Community Health Epidemiology & Surveillance (ARCHES); 2) Community Health Equity & Promotion (CHEP); and 3) Disease Prevention & Control (DPC). Together, we maintain strong collaborations with federal funders including CDC, HRSA, and SAMHSA, and we are members of UCHAPS and NASTAD. To ensure the communication, collaboration, and coordination needed to deliver a comprehensive local continuum of services, the SFDPH actively engages in multiple partnerships. Examples are:

- California Department of Public Health: SFDPH partners with the State Office of AIDS (see attached Letter); State Office of Viral Hepatitis Prevention regarding HCV testing, linkage, and treatment; and the State and Active Communities Branch on naloxone distribution.
- Neighboring counties: San Mateo and Marin counties, although no longer part of SF's funding jurisdiction, remain strong partners on the HCPC. SFDPH also partners with Alameda County to support their 90-90-90 initiative and coordinate DTC activities.
- CBOs: SFDPH has a rich network and healthy collaborations with dozens of funded and non-funded HIV prevention and care CBOs throughout SF, for service planning, implementation, and evaluation. Our current funded CBOs were invited to give input on this application at a meeting held on July 17, 2017.
- Partners within SFDPH: ARCHES, CHEP, and DPC collaborate with the SF Health Network (SFHN), which is the service delivery section of SFDPH, on several systems change initiatives, such as increasing routine HIV screening, strengthening HCV primary care treatment capacity, and expanding harm reduction approaches in substance use treatment. We also support direct services within SFHN, such as clinic-based PrEP, the PHAST team at Zuckerberg SF General Hospital, and retention navigation services. LINCS has strong connections with SFHN providers, which enhances navigation effectiveness.
- Collective impact efforts: ARCHES, CHEP, and DPC staff serve on the leadership and

committees of GTZ and End Hep C SF (EHCSF), providing input on programmatic strategy and data on key metrics and progress towards their achievement. This allows GTZ and EHCSF to identify gaps in services and seek funding – in fact, many of the Component A services are partly supported by funding that the GTZ Consortium raised. SFDPH also partners with Tenderloin Health Improvement Partnership to address environmental stress in this poor SF neighborhood related to substance use, homelessness, and other social determinants of health.

Target Populations and Health Disparities

This application proposes to reach people living with and at greatest risk for HIV in SF, as described in our Integrated Prevention and Care Plan. The focus continues to be on **high-prevalence populations** – MSM, PWID, and trans women – because these three populations together make up 97% of PLWH and 90% of new diagnoses. In addition, both Components A and B have a strong equity lens. Component A describes specific strategies to address identified health disparities and their underlying social determinants. For example, **Black and Latino MSM** are over-represented among new HIV diagnoses; we have put in place culturally specific PrEP programs for these populations that include ways to address barriers to PrEP, such as lack of insurance and housing instability. Layering an equity focus on top of an already strong foundation of prevention for high-prevalence populations will propel us further towards zero and achieve the goals of this funding announcement.

C. APPLICANT EVALUATION AND PERFORMANCE MEASUREMENT PLAN – See Attachment.

D. ORGANIZATIONAL CAPACITY OF APPLICANTS TO IMPLEMENT THE APPROACH

PHD Branch	HIV-Related Role
Community Health Equity & Promotion (CHEP)	Oversees community-based services; co-chairs the HCPC
Disease Prevention & Control (DPC)	Oversees clinically-based services including LINCS; houses City Clinic and the Public Health Laboratory
Applied Research Community Health Epidemiology & Surveillance (ARCHES)	HIV surveillance; DTC activities; data analysis and dissemination
Center for Learning & Innovation (CLI)	Capacity-building and communications
Center for Public Health Research (CPHR) & BridgeHIV	Clinical trials and intervention research
Office of Equity & Quality Improvement (OEQI)	Policy
HIV Health Services (HHS; part of SFHN)	Oversees Ryan White services; co-chairs the HCPC

SFDPH's mission is to protect and promote the health of all San Franciscans. We have two primary divisions: 1) the Population Health Division (PHD), where ARCHES, CHEP, and DPC are located, and 2) the San Francisco Health Network (SFHN), which includes the hospitals and clinics, behavioral health, HIV Health Services (which oversees Ryan White funding), and other direct health services. This means we have broad capacity across PHD and the health department to implement HIV prevention, despite the substantial funding reduction SF will receive from CDC under this program announcement. (We anticipate being able to achieve the desired outcomes even with reduced funding, through leveraging in-kind staff resources and expertise, improving service integration, and exploring efficiencies.) We maintain strong collaborations across the Branches to ensure a unified approach to HIV prevention, and use communication technology such as Sharepoint, GroupSite, and Zoom to ensure we are all aware of each other's efforts and are in sync. All our work is conducted under strict security and confidentiality

guidelines and procedures. All PHD branches accessing data with personal identifiers are required to adhere to the security and confidentiality guidelines of the CDC, the State Office of AIDS and the SFDPH. In addition, PHD has strong collaborations with the Department's Information Technology leadership and staff in order to manage the physical and technological infrastructure needed to support and maintain all PHD activities, including creating, modifying, and maintaining data systems to inform decisions across the Division.

i. Workforce Capacity

The SFDPH and PHD workforce is extremely experienced and competent with implementation of the 11 required strategies. First, we work hard to ensure that the focus populations are represented in the work force. For example, on staff are several gay men, including gay men of color; African Americans; Latinos/as; trans women; PLWH; and former substance users. Second, our leadership and staff have extensive experience in the strategies and interventions. To list a few examples, Thomas Knoble, who oversees community-based testing, has 25 years of experience in this area. Erin Antunez, LINCS Manager, has 9 years of experience. Jose Luis Guzman was once a community co-chair of the HIV Prevention Planning Council; now he is on staff, and serves as a government co-chair of the HCPC. Ling Hsu, Core Surveillance Director, has over 20 years of experience in HIV surveillance. Third, we have a strong track record of integrated prevention and surveillance program development, as demonstrated by our excellent DTC and, more recently, Data to PrEP programs that have resulted in improved re-linkage to care and increased pathways for identifying people who might benefit from PrEP.

ii. Staffing *(see attached program organizational chart)*

The Principal Investigator (PI) will be **Tomás Aragón, MD, DrPH**. Dr. Aragón is the Health Officer of the City and County of San Francisco, and the Director of PHD. He will be accountable for overall planning, implementation, monitoring, and reporting. **Tracey Packer, MPH, Susan Scheer, PhD, MPH** and **Susan Philip, MD, MPH** will serve as Project Co-Directors. Ms. Packer, CHEP Director, is responsible for community-based HIV prevention services. She is a recognized community leader, serves on the GTZ Steering Committee, and has over 20 years of experience in HIV prevention. Dr. Scheer is the Director of HIV Epidemiology and Surveillance within ARCHES, with over 20 years of experience in HIV research including over 10 years in HIV surveillance. She served as an original member of the CDC DTC Working Group and as an expert advisor on the CDC DHAP external review panel that recommended that CDC integrate the surveillance and prevention grants and funding. Dr. Philip, DPC Director, is a public health physician who is board certified in internal medicine and infectious diseases and has 12 years of experience in STD/HIV clinical, biomedical and disease intervention prevention strategies. She serves on the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC) and is co-Chair of the CHAC STD Workgroup. They will oversee work conducted by staff in their respective Branches, ensure fidelity to the work plans and evaluation plans, and maintain smooth implementation of the project. Key project implementation staff include: 1) ARCHES - **Ling Hsu, MPH,** Director of Core HIV Surveillance; 2) CHEP - **John Melichar,** Community-Based HIV Prevention Services Coordinator; **Dara Geckeler, MPH,** Evaluation and Quality Improvement Coordinator; and 3) **Stephanie Cohen, MD, MPH,** Medical Director of SF City Clinic and Section Director for HIV/STD Prevention; **Darpun Sachdev, MD,** Medical Director of LINCS. Further details on project staff, their expertise, and roles are available in the *Budget Narrative.*

E. WORK PLAN – See Attachment.

COMPONENT B DEMONSTRATION PROJECT NARRATIVE

A. BACKGROUND

> ***Project OPT-IN* Vision**
> A network of homeless services that meets the needs of people living with or at risk for HIV, providing them with all the resources and support needed to stay HIV-negative or virally suppressed.

SFDPH proposes to implement a novel demonstration project called *Project OPT-IN ("opt in" to Outreach, Prevention & Treatment)* to reduce **HIV-related disparities and health inequities** across the spectrum of prevention, care, and treatment for **homeless[b] populations living with and at risk for HIV.** Secondary target populations (many of whom are also homeless) include PWID, opioid users, and other substance users; women at risk/living with HIV, people with a history of incarceration, and PLWH co-infected with HCV. Local epidemiologic data continually show that these populations are not being effectively reached by current prevention strategies, and that they need to be reached in order for SF to "get to zero." People of color are disproportionately represented in these groups, and we expect *Project OPT-IN* to improve care continuum outcomes for African Americans and Latinos as well.

B. APPROACH

i. Purpose and Rationale

Project OPT-IN will improve HIV-related outcomes across the care continuum by **providing services** to address critical gaps in HIV prevention and care services for the target populations, while simultaneously working to **transform systems and practices,** thus reducing the long-term need for such services.

***Project OPT-IN* is critically needed.** Although SF has made great progress towards "getting to zero," not all populations have benefited equally. Of the 7,000 – 12,000 homeless people estimated to be living in SF, 11% are living with HIV[12]. **Viral suppression among homeless PLWH is 31%**[1] and homeless PLWH have higher rates of hospital utilization and substance use. This population experiences severe co-morbidities and barriers to care in addition to homelessness, including diagnoses of alcohol abuse (39%), drug abuse (49%) and psychoses (30%), and 48% did not have a medical home[13]. Unstable housing also has a negative impact on PrEP retention. Data from the US PrEP demonstration project show that unstable housing was associated with early loss to follow-up and intermittent retention on PrEP[14]. Inequities continue to exist across the care continuum for other *Project OPT-IN* priority populations as well. For example, overall, 73% of PLWH in SF are virally suppressed, compared with women at 66%, and PWID at 63%. Additionally, nearly 100 HCV/HIV-co-infected persons identified through surveillance data are not in care for their HIV.

***Project OPT-IN* meets HCPC and community priorities.** The goals of *Project OPT-IN* are well-aligned with San Francisco's Integrated HIV Plan (see attached HCPC letter of support).

***Project OPT-IN* is innovative and will identify promising practices for use in other jurisdictions.** SF's *Project OPT-IN*, in combination with the strategies in Component A, address the entire spectrum of HIV prevention and care for the all persons at risk for or living with HIV, especially those experiencing the greatest inequities. Lessons learned in SF will be applicable to other jurisdictions regardless of the demographic make-up of their HIV epidemic.

i. Outcomes

[b] The term "homeless" is inclusive of people experiencing homelessness chronically or intermittently, people who are marginally housed, including, for example, people who live in single room occupancy hotels.

Project OPT-IN aims to contribute to the following long-term goals: 1) Reduce the number of new infections among homeless persons, as measured by HIV surveillance; 2) Increase the proportion of newly diagnosed homeless persons who are linked to care within one month of diagnosis; 3) Increase retention in care among PLWH who were homeless at diagnosis; and 4) Increase viral suppression among PLWH who were homeless at diagnosis. The attached Evaluation and Performance Measurement Plan (EPMP) describes **the project period outcomes** and quantitative process measures and qualitative assessment that will measure progress made towards these goals and outcomes.

ii. Strategies and Activities

Homelessness is a significant and high-profile issue in SF. This has led to intensified efforts in recent years to improve collaboration across the multiple agencies and institutions serving this population. *Project OPT-IN* will ensure that HIV expertise and patient needs are front and center as these service providers re-invent their approach to homeless health, moving from "reactive mode" (red zone) to a wellness model (green zone) (Fig. 1). *Project OPT-IN* will take a parallel approach – providing HIV-specific services, while simultaneously building the capacity of existing systems of care to meet HIV-related needs, thus reducing the long-term need for these costly HIV-specific services.

FIG. 1: *Project OPT-IN*

Warm Handoffs

	Wellness & "whole person" care	Transition & stabilization services	Reactive, urgent & acute care	
	Clinic-based Care Coordination	**Community-based Intensive Case Management (ICM)**	**Short-Term Navigation (care and PrEP)**	**Mobile Medical/ Jail-Based Care**
Proposed Services	*LINCS HIV care coordinators embedded in clinics*	*ICM for homeless PLWH*	*Prevention Services Outreach Team (PSOT) will provide navigation*	*PSOT will provide HIV/HCV/STD testing and linkage to care*
Proposed Innovations	*HIV care coordination integrated into clinic workflows*	*ICM for HIV-negative people & PrEP users*	*Improve use of data for locating patients lost to care*	*DTC for homeless & Data to Care/Cure for PLWH with HCV*
Proposed Systems Change Efforts	1) Cross-agency integration of data, risk assessment, and care planning 2) Improve inter-agency and inter-program warm hand-offs 3) Integrate HIV and drug user health services into homeless services			

Red Zone Efforts – Mobile Medical Care and Short-Term Navigation

Services. A new SFDPH **Prevention Services Outreach Team (PSOT)** will implement homeless health outreach, both at the individual level and via organized inter-agency encampment health fairs. PSOT will be jointly coordinated by SFDPH's community health and clinical services branches. The team members and their roles are described in the budget narrative. PSOT will provide testing services, linkage to care, and short-term care and PrEP navigation.

Innovations. 1) Data to Care for Homeless. Using existing hybrid DTC methods (data from surveillance as well as clinical providers), the *Project OPT-IN* Data Science Team will generate lists of newly diagnosed and virally unsuppressed homeless individuals for PSOT, and PSOT will also actively seek referrals from providers. Priority will be given to PWID, women, and those with a history of incarceration. 2) DTC^2. SFDPH will pilot **a first of its kind Data to Care/Data to Cure (DTC^2)** effort. SFDPH will harness its extensive DTC experience and

multiple data sources (e.g., HIV and HCV surveillance data, patient medical records, SFHN HCV treatment data) to generate a list of NIC HIV/HCV-co-infected persons. PSOT will work the list, and offer HCV treatment to those located as an incentive to re-engage in HIV care. During the 8- to 12-week HCV treatment course, PSOT staff will work with the patient's medical team to lay the groundwork for continued HIV care engagement. We expect this to be successful, because SF's anecdotal experience and a recent study[15] have shown that patients undergo remarkable behavioral/psychological changes when their HCV is cured, such as increased energy and motivation, which can help to improve HIV care engagement. In addition, SFDPH has a robust infrastructure for HCV treatment with capacity to treat new patients. Between 2015 and 2016, SFDPH doubled the number of people treated for HCV.

One of the biggest challenges for SF navigation efforts is locating clients. The following innovations will **ensure that all possible data is harnessed for locating clients:** 1) Implement a data sharing portal with CBOs who provide HIV testing, care, and other services. Building on successful DTC efforts with SF primary care clinics, HIV surveillance and CBOs will securely share data so that we can collaborate to locate, link and retain clients in care and avoid focusing resources on patients who, per surveillance data, are actually in care elsewhere or have moved out of SF. 2) Secure real-time access to homeless shelter databases for LINCS and PSOT team members; and 3) Develop a system to alert LINCS by text and email when current or former LINCS clients are seen in the emergency room at Zuckerberg San Francisco General Hospital.

Yellow Zone Efforts – Community-Based Intensive Case Management

Services. Intensive case management is client centered and brings tailored services directly to the client. Glide and SFAF will provide ICM services, taking referrals from PSOT and LINCS.

Innovations. Homeless HIV-negative people at risk for HIV face the same barriers to staying HIV-negative/PrEP-adherent that PLWH face regarding viral suppression/ART adherence such as substance use, mental illness, and trauma. Glide and SFAF will pilot **ICM services with HIV-negative people.** In addition, more options for culturally competent low-threshold/low barrier services are needed for the target population to establish a "home base" where they feel comfortable receiving services and can be "found" if they are lost to clinical care. *Project OPT-IN* will build capacity of existing low barrier services (e.g., at SFDPH City Clinic's Early Care Program and SFAF's Harm Reduction Center). In addition, *Project OPT-IN* will work with CBOs to serve as a pilot **Health Access Points (HAPs)** – stigma-free environments where clients can access a constellation of low-threshold services (e.g., picking up and storing medications, using the phone or computer, drop-in peer support).

Green Zone Efforts – Clinic-Based Care Coordination

Services. Project OPT-IN will support clinic-based **HIV-Related Care Coordinators** for retention in care (PLWH) and on PrEP (HIV-negative). These staff will be part of the LINCS team and based at the two SFHN primary care clinics with the largest populations of homeless persons living with or at risk for HIV. Using clinical data, the Care Coordinators will identify patients at risk for falling out of care/off PrEP and develop strategies to support these patients, either at the clinics and/or through linking them to community-based ICM.

Innovation. By the end of the 4-year project period, HIV-related care coordination will be integrated into standard primary care workflows, reducing health care system reliance on HIV-specific resources for retention activities.

Systems Transformation

Cross-agency integration of data, risk assessment, and care planning. Project OPT-IN will

work to improve cross-agency data sharing, risk assessment, and care planning to ensure that the needs of people living with and at risk for HIV and HIV-related stigma are addressed once HIV-specific services are reduced or end. In addition, *Project OPT-IN* will train homeless services staff on core HIV knowledge and skills.

Strengthen staff skills to address HIV-related issues. 1) *Project OPT-IN* will provide **public health detailing with clinicians and frontline staff** to address gaps in knowledge and skills related to HIV management, retention, and prevention, including how to deliver services in a way that does not perpetuate stigma. See attachment for an example of public health detailing materials that educate on how providers can get support to retain patients. 2) *Project OPT-IN* will also fund **training for homeless services direct service staff and managers on trauma-informed care and harm reduction training** to increase skills and cultural competence in working with the target population.

Improve inter-agency and inter-program warm hand-offs for homeless HIV-positive and HIV-negative clients. In SF, homeless services and public health systems reach the same clients, yet are silo-ed. *Project OPT-IN* will help to **improve warm hand-offs between these two systems.** Goals include: 1) increasing the timeliness of patient referrals and hand-offs to other agency/programs; and 2) improving the appropriateness of the referrals/hand-offs such that patients receive services commensurate with their level of need. *Project OPT-IN* will work within the network of homeless services to define referral pathways that promote use of yellow and green zone services, and develop clear criteria for making appropriate referrals to LINCS, ICM, and Care Coordinators.

Integrate HIV- and drug user health-related services into settings serving homeless people. *Project OPT-IN* will work to increase integration of routine HIV/HCV/STD testing and linkage, naloxone distribution, syringe access referrals, and other HIV and harm reduction services in settings such as substance use treatment, jails, pre-trial and post-release programs and other locations.

C. APPLICANT EVALUATION AND PERFORMANCE MEASUREMENT PLAN - See Attachments.

D. ORGANIZATIONAL CAPACITY OF SFDPH TO IMPLEMENT THE APPROACH

SF has foundational experience with the proposed activities (see below). In recent years, SFDPH has built capacity to work with the target population through the SFDPH Homeless HIV Outreach and Mobile Engagement (HHOME) Program (>60% of patients achieved viral suppression at least once) and LINCS (no difference in linkage to care outcomes between homeless and housed patients). The staffing plan, experience and expertise, and contributions to this project are available in the *Budget Narrative.*

***Project OPT-IN* Key Collaborators**
- Department of Homeless and Supportive Housing (see attached letter of support)
- CBOs Glide and San Francisco AIDS Foundation (see attached Memorandum of Agreement)

ARCHES	
Implements Data to Care and Data to PrEP; Maintains data portal and sharing with CBOs	
CHEP	DPC
• Oversees SFDPH Drug User Health Initiative (HCV prevention, syringe access, overdose prevention, harm reduction training) • Conducts street outreach reaching PWID and participates in homeless encampment health fairs	• Provides short-term navigation services to NIC homeless patients (~30 - 40% of LINCS clients) • Implemented public health detailing reaching >300 providers with education about PrEP, rapid linkage to care, HIV retention, and sexual health

E. WORK PLAN – See Attachments.

COMPONENT A WORK PLAN

A. FIVE-YEAR PROJECT OVERVIEW

Strategy 1: Systematically collect, analyze, interpret, and disseminate HIV data

SFDPH will conduct ongoing **core HIV surveillance activities** and **HIV prevention program evaluation** to identify specific populations at risk for HIV and living with undiagnosed HIV and to assess trends and disparities along the HIV Care Continuum. The **data will be shared** with clinical and community-based providers and SF's integrated HIV prevention and care planning group, the HIV Community Planning Council (HCPC), and **HIV prevention strategies will be rapidly adjusted** to align with the most current trends.

Strategy 2: Identify persons with HIV and uninfected persons at risk for HIV[1]

SFDPH will continue to support **high-volume, targeted testing** to high-prevalence populations (MSM, PWID, and trans women) as well as casting a wider net to reach populations not yet reached with the current testing strategy. RNA pooling and 4th generation rapid testing continue to enhance our testing strategy by making individuals aware of their acute HIV status, reducing risk to partners and linking to care faster. SFDPH will also reinvigorate medically based opt-out HIV testing and work to find late testers earlier in their course of infection as well as the estimated 7% of PLWH who are unaware of their infection.

Strategy 3: Maintain HIV transmission cluster/outbreak response plan

SFDPH, as a previous Molecular Surveillance funded jurisdiction, is experienced and well-equipped to develop a Cluster/Outbreak Response Plan and investigate clusters (via the Linkage Integration Navigation, Comprehensive Services [LINCS] team). Additionally, we will implement **Secure HIV-TRACE to analyze HIV nucleotide sequences and identify molecular clusters at the local level.** We will work with Project Inform, a community think tank, to engage the community, building knowledge and support for these activities (see Project Inform letter of support).

Strategy 4: Provide comprehensive HIV-related prevention services for diagnosed PLWH

SFDPH will strengthen, streamline, and address gaps in linkage and retention services for PLWH, with the goal of establishing a clear, patient-centered process from point of diagnosis through accessing and staying engaged in HIV care. The strategy will include **Data to Care** activities; centralized linkage and re-engagement activities through the **LINCS program,** and other key retention efforts, especially for populations with the greatest barriers to care.

Strategy 5: Provide comprehensive HIV prevention services for HIV-negative persons

SFDPH will continue to expand access to **PrEP,** through its Project PrIDE funding and collaboration with Getting to Zero. The SF PrEP outreach and uptake strategy includes the City Clinic PrEP program, seven community-based programs, a pharmacy-based pilot program, and

[1] See Strategy 4 for Data to Care activities.

several other efforts that include structural and systems change initiatives. **Health education and risk reduction efforts** will be highly focused on addressing HIV-related disparities.

Strategy 6: Conduct perinatal HIV prevention and surveillance activities

SFDPH has not had a case of perinatal HIV since 2005 and therefore will continue its current strategy of perinatal HIV prevention–supporting **universal testing** of pregnant women and **collaborating with the UCSF HIVE Program,** which provides pre-conception and prenatal services for women living with HIV and women with HIV-positive partners (see HIVE letter of support). SFDPH will continue routine case surveillance including women diagnosed with HIV and their infants if they meet the HIV case definition.

Strategy 7: Conduct community-level HIV prevention activities

SFDPH will continue to support its highly effective **syringe access and disposal program,** while working with the City and community partners to expand access to safer injection. **Condom distribution** will also continue, accompanied by updated **data-driven messaging** addressing the role of condoms in the era of PrEP and increasing STD rates. Social marketing will be implemented as needed, and community mobilization will focus on communities of color.

Strategy 8: Develop partnerships to conduct integrated HIV prevention and care planning

2018 will mark the third year of SF's integrated planning group – **HIV Community Planning Council (HCPC).** SFDPH will continue to engage the HCPC in **data-driven planning** through annual and as-needed presentations and discussions focusing on trends in the HIV Care Continuum by demographic groups. Population-based surveillance data as well as community and program-level data will inform this process.

Strategy 9: Implement structural strategies to support HIV surveillance and prevention

SFDPH has a strong history of collaboration between HIV surveillance and prevention programs including sharing data for Partner Services, Data to Care activities and Data to PrEP. We will continue to address barriers to data sharing in order to further improve the integration of surveillance, program, and clinical data; work toward integrating our databases into one system for HIV, STD and prevention services; develop data-driven HIV prevention efforts; and protect patient/client privacy. Additionally, we will explore new sources of data, from private sector health systems and pharmacies for example, to facilitate our activities.

Strategy 10: Conduct data-driven planning, monitoring, and evaluation

SFDPH, in collaboration with the Getting to Zero Consortium, is developing a formalized system for data-driven planning, monitoring, and evaluation using **"scorecards"** developed using the Results-Based Accountability framework (Friedman). Program-level, strategy-level, and collective impact scorecards will illuminate successes as well as disparities and gaps that need to be addressed. We will continue to **disseminate our data** widely through scientific publications, conference presentations, community meetings, semi-annual and annual reports and meetings with our international, national, state and local colleagues. Quality improvement efforts to ensure surveillance data is accurate, complete and timely and continues to meet all CDC performance standards will continue.

Strategy 11: Build capacity for HIV program, epidemiology, and geocoding activities

2018 will be an intensive capacity-building year for SF's HIV prevention CBOs. SFDPH will work closely with CBOs to plan for shifts in HIV prevention strategies and activities (1-7 above). CBA needs will be assessed and CBA plans developed annually thereafter. SFDPH has been conducting Data to Care activities as a joint activity between HIV surveillance and the LiNCS program since 2012 when we conducted the pilot study RSVP: "Re-engaging Surveillance-identified Viremic Patients in Care" and Data to Care activities have increased with CDC PrIDE funding in recent years. Drawing on past experience, we will refine and improve our Data to Care efforts in the next five years and apply lessons learned in Data to Care to local Data to PrEP efforts. SFDPH surveillance collects complete address at time of diagnosis and current address is updated through routine follow-up chart abstraction. This information is geocoded to the census tract level and maps showing, for example, the geographic distribution of all PLWH, newly diagnosed cases, and their viral suppression and linkage to care rates as well as testing rates by neighborhood and zip code are produced and shared in our annual epidemiology report. SFDPH does not anticipate any epidemiologic CBA needs.