San Francisco Department of Public Health
High-Impact HIV Prevention & Surveillance Programs for Health Departments
Response to CDC-RFA-PS-24-0047

TABLE OF CONTENTS

A. BACKGROUND

As a result of hard-fought accomplishments in prevention, care, and treatment services, and informed by a robust HIV surveillance system, SF is on a trajectory to 'Get to Zero': zero new HIV infections; zero HIV deaths; and zero HIV stigma. SF's data-driven high impact prevention **(HIP)** strategy has resulted in significant and steady reductions in new HIV diagnoses and increasing linkages to care and viral suppression among people living with HIV **(PWH).** For over a decade, the number of new HIV diagnoses has declined, dropping to 179 in 2019, a 67% decrease from 2006.[1] Since 2019, the rate of decline has slowed, with 157 new diagnoses in 2022.

Overall, 97% of PWH in SF are aware of their HIV status. In 2022, 90% of those newly diagnosed were linked to care within one month of diagnosis and 80% of those diagnosed in 2021 were virally suppressed within one year. Between 2018 and 2021, the median number of days from HIV diagnosis to first care visit was one day, and zero days to ART initiation. No children (age <13) have been diagnosed with HIV since 2005, representing the success of perinatal programs providing preconception counseling and pre- and post-natal care to women living with HIV.

However, persistent disparities in HIV outcomes, as well as HCV and STI outcomes, by race/ethnicity, housing status, transmission risk group, and gender remain. These disparities, driven by intersecting social determinants of health **(SDoH)**, and the overlapping populations at risk, call for the use of a syndemic framework with coordinated strategies and fully integrated systems and programs. With our extensive network of community-based and clinical providers and collaborations, a committed advocacy community, and strong track record of rapid implementation of prevention, clinical, biomedical, and research advances, SF is well-positioned to apply a SDoH approach and strengthen key partnerships to mitigate the effects of SDoH on HIV/HCV/STI prevention, testing, and treatment.

B. APPROACH

i. Purpose

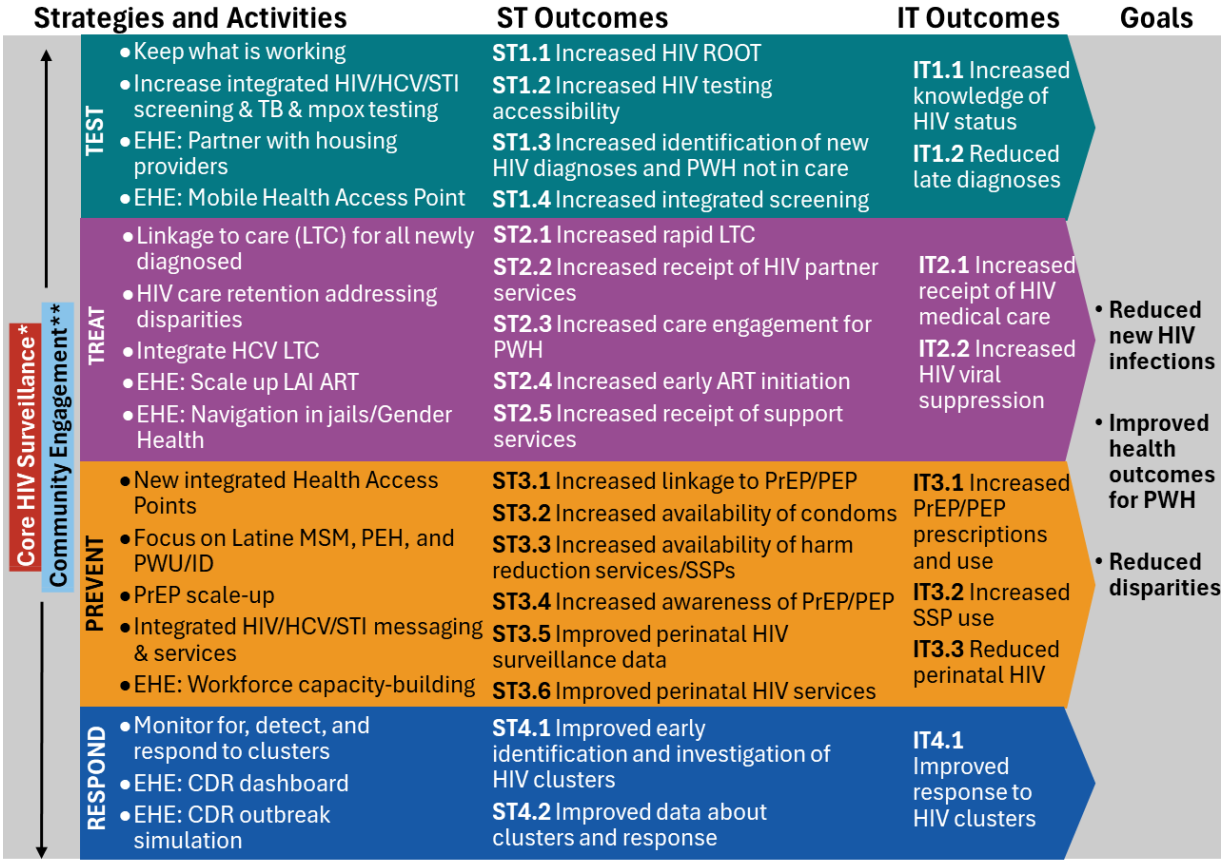
SF's integrated surveillance, prevention, and response program will maintain its strong emphasis on HIP, with additional focus given to the interconnectedness of HIV, HCV, and STIs and the shared SDoH affecting health outcomes, including substance use, mental health, homelessness, poverty, racism, homophobia, and transphobia, among others. SF will implement "Ending the Epidemics" **(ETE)** through a fully integrated system of care that is person-centered, not disease-centered. SF's whole-person care approach aims to meet a person's comprehensive medical, mental health, substance use, housing, social, and other needs, with the goal of getting to zero for HIV, ending HCV, and turning the curve on STIs.

ii. Outcomes

By the end of the performance period, SFDPH will have achieved the short-term **(ST)** and intermediate-term **(IT)** outcomes that are consistent with the period of performance outcomes described in the NOFO and logic model, as depicted in **Exhibit 1.** The colors used in Exhibit 1 correspond to those used throughout our work plan to designate activities in the test, treat, prevent, respond, core HIV surveillance, and community engagement categories.

[1] All data in this application is from the most recent SF HIV, HCV, or STI published report, unless noted.

Exhibit 1: San Francisco's Ending the HIV Epidemic Logic Model



Core HIV Surveillance & Community Engagement strategies support successful activity implementation, leading to

***ST5.1** Improved HIV surveillance data for public health action; ST5.2 Improved monitoring of HIV trends; ST5.3 Improved data security, confidentiality, and protections; IT5.1 Improved use of HIV surveillance data to identify syndemics; IT5.2 Improved electronic data exchange capacity; IT5.3 Improved visualization of HIV surveillance data for public health action

****ST6.1** Increased collaborations and engagement with communities; ST6.2 Increased coordination and access to comprehensive HIV services; IT6.1 Sustained community partnerships

iii. Strategies and Activities

In 2023, SFDPH implemented a new service model as part of the shift to a syndemic SDoH-focused approach—Health Access Points **(HAPs) (Exhibit 2).** The HAPs, funded and overseen by the Community Health Equity and Promotion **(CHEP)** Branch, are an integrated, low-barrier HIV/HCV/STI service model, where each HAP delivers services for a specific priority population. Each HAP (lead agency and priority population shown in **Exhibit 2**) is required to provide 13 standards of care **(Exhibit 3).** A key priority for this project period is to nurture and grow the HAPs into fully functioning "one-stop shops." This overview of the HAPs is provided here because many of the activities described later in this section relate to the HAPs.

Exhibit 2: San Francisco Health Access Points

Health Access Points	A&PI	Black/AA	Latine	MSM	PWUD	TAY	Trans women
	"LOTUS"	"Umoja"			"The Lobby"		"STAHR"

Exhibit 3: San Francisco Health Access Point Standards of Care

Integrated HIV, HCV, and STD testing ● Linkage and navigation to PrEP, HIV care, HCV treatment, STD treatment, primary care, and other services ● Substance use harm reduction services (including for opioids, stimulants, alcohol, tobacco, cannabis) ● Syringe access and disposal ● Overdose prevention (including naloxone distribution) ● Condom distribution ● Community engagement and mobilization (physical and online, social media) ● Prevention and treatment medication: PrEP and ART for HIV; HCV treatment; STD treatment, including medication storage ● Services to meet basic needs (examples: food, housing, employment) ● Primary care ● Substance use treatment ● Mental health services

Strategy 1: Test

SF has already exceeded the CDC target of 95% status awareness, with 97% of PWH in SF aware of their HIV status. Much of this success can be attributed to the HIV testing scale-up that began in 2012 as part of SF's HIP strategy. In 2024, HIV testing is widely and easily available in SF. Our approach to **TEST** over the next 5 years will be: **1) keep what has worked; 2) increase and integrate screening for HCV and STIs and ensure TB and mpox testing are available; and 3) implement some highly focused efforts for testing among people experiencing homelessness.** Specific activities are as follows, with workplan details for each[2]:

CDC 1A: HIV testing in health care settings, including routine opt-out HIV screening

SF1.1 Continue to implement routine opt-out (ROOT) HIV testing, supported by public health detailing staff and clinical champions. ***(Responsible: Alyson Decker)*** Current SF Health Network **(SFHN)** sites conducting HIV ROOT include the Zuckerberg SF General Hospital **(ZSFG)** (opt-out HIV screening for all patients admitted to the hospital); Whole Person Integrated Care **(WPIC);** integrated primary care/behavioral health for people experiencing homelessness **(PEH)**; and Primary Care (lifetime annual test, with repeat annual screening for those at higher risk). *CDC Outcomes ST1.1, ST1.2, ST1.3, IT1.1, IT1.2*

- **SMART Obj. Y1:** By 5/31/25, conduct at least one public health detailing visit to current HIV ROOT sites to assess the status of ROOT and provide any necessary support.
- **SMART Obj. Y2-5:** By 5/31/29, expand ROOT HIV testing to additional settings that are potentially high-yield in terms of diagnosing new infections.

SF1.2 Continue to implement routine perinatal HIV testing in SFDPH Labor & Delivery, and diagnostic HIV testing for exposed infants in the SFDPH Pediatrics Department and WPIC. ***(Responsible: Alyson Decker)*** Routine perinatal testing is well established in SF. No children (age <13) have been diagnosed with HIV since 2005, representing the success of perinatal programs that provide preconception counseling and pre- and post-natal care to PWH who are or could become pregnant. *CDC Outcomes ST1.1, ST1.2, IT1.1, IT1.2*

- **SMART Obj. Y1-5:** Throughout the project period, continue HIV ROOT and HIV screening for all people who are pregnant, during pre- and post-natal care, and HIV diagnostic testing for all perinatally exposed infants, continuing to have no infants born with HIV.

CDC 1B: HIV testing in non-health care community settings, including HIV self-testing

SF1.3 Implement integrated HIV, HCV, and STI community-based testing at the seven HAPs and continue integrated screening at SF City Clinic (SFCC). ***(Responsible: Thomas Knoble)*** All

[2] Instead of a stand-alone workplan, the workplan for each activity is integrated into this section (person(s) responsible, SMART objectives for Y1 and Y2-5, and related outcomes from the CDC logic model, denoted as ST [short-term] and IT [intermediate-term]. Refer to Exhibit 1 on p. 2 for the numbered list of outcomes.

seven HAPs are contractually required to offer HIV, HCV, and STI testing on site. *CDC Outcomes* ST1.2, ST1.3, ST1.4, IT1.1

- **SMART Obj. Y1:** By 5/31/25, four of the seven HAPs and SFCC will be providing HIV and HCV testing, as well as pharyngeal, vaginal, and rectal chlamydia/gonorrhea and syphilis testing.
- **SMART Obj. Y2-5:** By 5/31/29, all HAPs and SFCC will be providing HIV/HCV/STI testing.

SF1.4 Continue to partner with TakeMeHome (TMH), a mail order home-based HIV and STI self-testing program, to increase access to testing. ***(Responsible: Nikole Trainor)*** SF currently partners with TakeMeHome to provide free mail order kits with: HIV dried blood spot test, STI self-test kits (oral, vaginal, and anal swabs, and urine for chlamydia/gonorrhea; dried blood spot for syphilis), and HCV tests for eligible participants. Users of social networking apps such as Grindr, Instagram, Facebook, X (formerly Twitter), and TikTok (as applicable) can order kits online (takemehome.org, Havegoodsex.org) or via mobile (by texting "Good" to 21203). Users can access their lab-based results through a secure portal. SFDPH will continue to partner with TakeMeHome to expand self-testing to all San Franciscans, with a priority on communities that continue to bear a disproportionate burden of HIV/STI. *CDC Outcomes ST1.2, ST1.3, ST1.4, IT1.1*

- **SMART Obj. Y1:** By 5/31/25, promote TMH through creative social marketing placement strategies, using websites, social media engagement, dating apps, TV, radio, YouTube, community-sponsored events, and the mobile SMS texting platform Mobile Commons.
- **SMART Obj. Y2-5:**
  - By 5/31/29, expand promotion of TMH to EHE priority populations, specifically Latine and Black cis women, increasing utilization by 10% annually.
  - By 5/31/29, increase kit return rate to 75%.
  - By 5/31/29, begin offering the ability to order individual tests.

SF1.5 Expand HCV and STI screening in clinical settings, and improve linkages to TB testing and symptomatic mpox testing, supported by public health detailing staff and clinical champions. ***(Responsible: Alyson Decker)*** Starting with sites already implementing HIV ROOT, public health detailers will support the integration of multiple sexual and substance use health services, including HCV/STI/TB/mpox testing, PrEP, doxy-PEP, eligibility screening/linkage, and linkages to syringe access and overdose prevention services. Detailers will work with sites to determine how best to implement testing/screening in that setting. *CDC Outcomes ST1.4, IT1.1, IT1.2*

- **SMART Obj. Y1:** By 5/31/25, identify the patient and/or provider tools most needed to expand screening and linkage to care for syndemic conditions, based on clinical setting.
- **SMART Obj. Y2-5:** By 5/31/29, develop and disseminate tools identified in year one to improve integration of syndemic conditions and linkage to care.

EHE Activities

SFEHE1.6 Collaborate with the Department of Homelessness and Supportive Housing (HSH) to improve access to HIV/HCV/STI testing, sexual health services, and overdose prevention services for people currently or formerly experiencing homelessness (PEH). ***(Responsible: Hanna Hjord)*** SFDPH will deepen its relationships with the city department responsible for homelessness and housing services, as well as supportive housing site managers and tenant leaders, to develop and implement a strategy for integrating testing, prevention, syringe services, overdose prevention, behavioral health services, and sexual health services into

shelters, navigation centers, supportive housing sites, and single-room occupancy (SRO) hotels. *CDC Outcomes ST1.2, ST1.3, ST1.4, IT1.1*

- **SMART Obj. Y1:** By 5/31/25, develop a plan and MOUs with HSH and the Office of Overdose Prevention to implement integrated HIV/HCV/STI testing and other sexual/substance health services at HSH housing sites, and to increase availability of overdose prevention services in permanent supportive housing sites.
- **SMART Obj. Y2-5:** By 5/31/29, implement plan, and make ongoing adjustments as needed.

SFEHE1.7 Expand SFDPH capacity for mobile testing and other prevention services. ***(Responsible: Hanna Hjord)*** SFDPH, in partnership with the WPIC Street Medicine Team and the HAPs, will develop a locally tailored, integrated, harm reduction-based mobile services model for HIV/HCV/STI testing and other prevention services, including overdose prevention and low-threshold access to medication-assisted treatments (MATs) such as naltrexone, methadone and buprenorphine. Currently, SFDPH teams up with several partners to provide mobile services on an ad hoc basis; EHE funding will allow SFDPH to formally establish a mobile HAP that brings services to various locations on a regular and routine basis, via mobile van or on foot, depending on the location. Priority neighborhoods include the Bayview and Mission, where a substantial percentage of the population is Black and Latine, respectively. *CDC Outcomes ST1.2, ST1.3, ST1.4, IT1.1, IT1.2*

- **SMART Obj. Y1:**
  - By 5/31/25, develop a program plan and MOUs in collaboration with Street Medicine, SFDPH Behavioral Health Services, existing HAPs, and other key partners for a mobile HAP, to reach PEH and other neighborhoods.
  - By 5/31/25, establish a Mobile Services Collaborative that will bring together key SF stakeholders and programs to collectively support, guide and advance mobile services.
- **SMART Obj. Y2-5:**
  - By 5/31/26, bring the mobile HAP to the Bayview and Mission neighborhoods on a regular and recurring basis.
  - Between 5/31/26 and 5/31/29, bring the mobile HAP to additional locations as determined using a data-driven process.

Strategy 2: Treat

SF is a model for rapid linkage to care **(LTC)** and HIV treatment. Between 2018 and 2022, 90% or more of newly diagnosed people started care within 1 month of diagnosis, with a median of 1 day from diagnosis to care and a median of 0 days from care to ART initiation. SFDPH's nationally renowned Linkage, Integration, Navigation and Comprehensive Services program (LINCS), housed at SF City Clinic, offers LTC and partner services to all individuals newly diagnosed with HIV in SF. Even during 2021, when COVID-19 dramatically impacted service delivery, 81 not-in-care **(NIC)** PWH enrolled in LINCS navigation, 75% linked to care within 3 months, and 64% were virally suppressed within 12 months—all significant successes given the complexity of LINCS patient needs and COVID-related challenges. LINCS collaborates with SF's community-based HCV LTC program to support HIV/HCV co-infected patients with linkage to HCV care.

Among most populations with HIV in SF, a high percentage are virally suppressed (>85%). However, SDoH and their differential impact on vulnerable and under-resourced populations result in disparities in retention in care and viral suppression. Among PWH who were SF residents as of the end of 2022 and who were in care (at least one lab test in 2022), the viral suppression percentage was lower among Black/African Americans (87%) and Latine (92%) PWH compared with whites (95%). Likewise, the viral suppression percentage among PWID ranged from 80–88% (with trans and non-MSM PWID lower than MSM-PWID), compared with 95% among MSM. There is an alarming disparity among PEH, among whom 74% were virally suppressed compared with 94% of housed PWH.

These data call for new strategies, and with core and EHE funding, SF will expand services for priority populations. **Our approach to TREAT over the next 5 years will be: 1) continue to offer LTC to all people newly diagnosed with HIV via LINCS; 2) focus HIV retention in care efforts on populations with the greatest disparities who are at higher risk for falling out of care; 3) better integrate HCV LTC into existing services; and 4) work with the HAPs, SF City Clinic, and Jail Health Services to scale up long-acting injectable (LAI) ART and other innovative strategies for LTC and retention for priority populations.** Specific activities are as follows:

CDC 2A: Link all people who test positive for HIV to medical care within 30 days, provide partner services, & provide prevention/essential services to support improved quality of life.

SF2.1 Offer clients who test positive for HIV immediate support with RAPID ART start, linkage to HIV primary care, and partner services. ***(Responsible: Erin Antunez)*** LINCS Disease Intervention Specialists (DIS) will continue to offer these services to all newly diagnosed individuals and attempt to improve retention rates by incorporating retention planning into the initial linkage process. *CDC Outcomes ST2.1, ST2.2, ST2.4, ST2.5, IT2.1, IT2.2*

- **SMART Obj. Y1:** By 5/31/25, offer all those in SF who test newly HIV-positive immediate support with RAPID ART start, linkage to HIV primary care, partner services, and resources/ support services to meet basic needs (e.g., food, clothing).
- **SMART Obj. Y2-5:**
  - By 5/31/26, develop a retention booklet or pocket card with key evidence-based counseling messages to promote long-term retention in care.
  - Between 6/1/26 and 5/31/29, identify newly diagnosed patients from the prior year who are not or are no longer linked to care or are not virally suppressed by using a data-to-care (D2C) list (generated by HIV Surveillance).

SF2.2 Prioritize re-engagement in care services for priority populations NIC, using both an HIV surveillance D2C approach as well as by working with SFHN primary care providers to identify NIC patients in their panels. ***(Responsible: Erin Antunez)*** NIC patients will be identified using referrals from primary care providers for patients who are lost to care or at risk, as well as D2C lists. D2C lists of a focused subpopulation will be generated annually. LINCS will use a range of disease investigation tools and databases to locate patients and work with them for up to 90 days to re-engage them in care. *CDC Outcomes ST2.3, IT2.1, IT2.2*

- **SMART Obj. Y1:** By 5/31/25, reinvigorate at least one HIV primary care collaboration that became inactive during the COVID pandemic, to re-link their NIC patients.
- **SMART Obj. Y2-5:**

- Between 6/1/25 and 5/31/29, continue to work with primary care providers to receive referrals for NIC patients and locate and re-engage them in care.
- Between 6/1/25 and 5/31/29, generate an annual D2C list for a focused subpopulation to identify persons NIC or not virally suppressed, and locate and re-engage them in care.

SF2.3 Implement HCV linkage to care for HIV/HCV co-infected and HCV mono-infected individuals. ***(Responsible: Rachel Grinstein)*** SFDPH will continue to provide HCV LTC as an essential service component at the HAPs, within the jails, and at SFCC, and will continue to implement community-based HCV navigation to support access to and successful completion of HCV treatment. CHEP currently partners with SF AIDS Foundation, Glide, Shanti, and HealthRight360 to provide HCV treatment navigation services for patients disengaged from traditional primary care, and will work closely with these programs to improve services through staff trainings, resource development, and relationship building. CHEP will continue to facilitate a monthly HCV care coordination meeting to improve linkages from community testing to HCV navigation and treatment services and to streamline care coordination systems for patients being served across programs. *CDC Outcomes ST2.1, ST2.2, ST2.4, ST2.5, IT2.1, IT2.2*

- **SMART Obj. Y1:** By 5/31/25, develop an updated program plan in collaboration with current HCV navigation partners and HAPs to ensure HCV LTC and navigation services are available at multiple community sites.
- **SMART Obj. Y2-5:** By 5/31/29, utilize targeted sub-analyses of SFDPH's HCV surveillance registry to inform new program strategies and identify priority areas to focus outreach and client engagement efforts.

EHE Activities

SFEHE2.4 Partner with key stakeholders to expand LAI ART with a focus on Black, Latine, PEH, and PWUD. ***(Responsible: Alyson Decker, Hanna Hjord)*** A 2023 landscape analysis of LAI ART and PrEP found that among six SF sites offering LAI ART to a total of 68 patients, Black, Latine, and unhoused/unstably housed people made up 25%, 28%, and 20% of LAI ART patients, respectively—higher proportions compared with the percent of PWH who are Black, Latine, or PEH. ZSFG's Ward 86 and WPIC are ideal locations to work on making LAI ART more accessible. Ward 86 is home to the POP-UP clinic, which provides low-threshold, relationship-centered care and enhanced outreach for PWH who are unhoused and not virologically suppressed. In addition, Ward 86 is the lead provider for the PWUD HAP, and WPIC is offering low-barrier access to LAI at the Maria X. Martinez (MXM) clinic, which serves PEH and PWUD. SFDPH will also emphasize LAI ART as a key service in its collaboration with HSH (see Activity SFEHE1.6), partner with Getting to Zero on any pilot or feasibility studies, and work with LAI ART providers to plan for sustainability of this service, which requires significant resources for patient outreach and follow-up. *CDC Outcomes ST2.4, IT2.2*

- **SMART Obj. Y1:** By 5/31/25, increase the number of clinics with implementation and sustained support to offer LAI ART from six to eight sites.
- **SMART Obj. Y2-5:** Expand LAI ART (on site or through warm hand-offs) to all seven HAPs.

SFEHE2.5 Partner with programs in settings serving priority populations to provide comprehensive support to people with HIV, HCV, or STIs, including Jail Health Services and Gender Health. ***(Responsible: Hanna Hjord [Jail Health]; Thomas Knoble [Gender Health])*** SFDPH will embed navigators in the SF jails and Gender Health to link people to comprehensive

medical care and behavioral health and other support services. In the jails, the navigator coordinates care and plans post-release services, meeting clients directly upon their release from jail (especially for those released at night, when regular services and support systems are unavailable). A Gender Health SF Peer Health Education and Pathways Navigator provides vital support to individuals referred for gender-affirming surgeries within the program, including peer sexual health education, engagement in care support, and surgical education. Given the high prevalence of HIV, HCV, and STIs among incarcerated populations and trans women in SF, these navigation programs offer opportunities for linkages to integrated testing and treatment. *CDC Outcomes ST2.1, ST2.2, ST2.3, ST2.5, IT2.1, IT2.2*

- **SMART Obj. Y1-5: Jail Health** Between 8/1/24 and 5/31/29, expand HIV/HCV/STI treatment, care, and prevention navigation services to three HAP sites to establish a comprehensive, streamlined service model for people who are newly released from SF County Jail.
- **SMART Obj. Y1-5: Gender Health** Between 8/1/24 and 5/31/29, the Gender Health navigator will offer enhanced navigation services to 20 Gender Health patients each year who are referred for gender-affirming surgeries and who are identified as high risk for HCV, STI, and HIV acquisition.

Strategy 3: Prevent

In SF, PrEP coverage (the percentage of people prescribed PrEP among those that are eligible) is estimated at 76%, compared to 30% nationally. PEP is easily accessible through SF City Clinic. Although the percentage of new HIV diagnoses occurring among PWID since 2013 has trended slightly upward, this is primarily a function of dramatic declines in new diagnoses among other groups, such as MSM; in fact, the number of new diagnoses among this group declined more than 50% between 2013 and 2022. There have been no perinatally transmitted HIV cases since 2005. Collectively, these data suggest that SF's HIP strategy has been extremely successful. As such, SF will stay the course, but bring an increased focus to populations that have not experienced as much benefit from the strategy. **Our approach to PREVENT over the next 5 years will be: 1) nurture and grow the HAPs so they can realize their potential as fully integrated low-barrier service models; 2) implement specific prevention efforts for Latine MSM, PEH, and PWU/ID (three populations that have not experienced the same rate of decline in new HIV infections as other groups); 3) optimize PrEP through scale-up and improved access; and 4) better integrate messaging and services for HCV and STIs with HIV.**

Cross-Cutting Activity: Health Access Points

SF3.1 Provide training and technical assistance to support the HAPs to provide fully integrated whole-person services to priority populations. ***(Responsible: Thomas Knoble)*** CHEP has multiple workforce development/capacity building/technical assistance resources available to its funded community partners. CHEP Program Liaisons will provide training and technical assistance to the HAPs. In addition, CHEP convenes a monthly meeting of the HAPs to share best practices, facilitate collaboration, and share and solve challenges. *CDC Outcomes ST3.1–ST3.4, IT3.1, IT3.2; Addresses CDC Activities 3A-3C*

- **SMART Obj. Y1:** By 5/31/25, four of the seven HAPs will meet the requirements for at least ten standards of care (**Exhibit 3,** p. 3).
- **SMART Obj. Y2-5:** Between 6/1/25 and 5/31/29, all seven HAPs will meet the requirements for all thirteen standards of care.

CDC Activity 3A: Support and promote awareness of and access to PrEP and PEP

SF3.2 Expand access to PrEP for PEH and PWU/ID. ***(Responsible: Hanna Hjord)*** A key factor contributing to SF's high level of PrEP coverage is the multiple low-barrier access points. PrEP is accessible via the HAPs, SF City Clinic, SFDPH Primary Care, and SFDPH Street Medicine. Mission Wellness Pharmacy provides pharmacy-based PrEP with in-kind support and medical oversight from SFDPH. During the project period, SFDPH will continue to support these models and bring existing and new partners to the table. CHEP will facilitate collaboration across the many programs serving these populations to scale up and improve PrEP access. Key partners include WPIC; the proposed mobile HAP; The Lobby HAP serving PWU/ID; ZSFG Ward 86 POP-UP clinic serving PEH; SFDPH Behavioral Health, which oversees syringe programs; the Office of Overdose Prevention; HSH and its housing programs; and Jail Health Services. In addition, CHEP will work with these partners to scale up LAI PrEP where feasible. *CDC Outcomes ST3.1, ST3.4, IT3.1*

- **SMART Obj. Y1:** By 5/31/25, develop a plan for implementing sexual health services, including PrEP, in supportive housing sites.
- **SMART Obj. Y2-5:** Between 6/1/25 and 5/31/29, develop and implement a plan for strategic expansion of LAI PrEP services, including systems for warm hand-off and linkage to LAI PrEP and renewal of the Mission Wellness Collaborative Practice Agreement to allow for provision of pharmacy-based LAI PrEP.

CDC 3B: Conduct condom distribution

SF3.3 Make free condoms and safer sex supplies widely available. ***(Responsible: Thomas Knoble)*** The HAPs, the Ryan White-funded Centers of Excellence (CoEs), and SFCC all provide free condoms and safer sex supplies. In addition, CHEP distributes condoms at community venues (e.g., bars) and events (e.g., Carnival, Pride, and Folsom Street Fair). *CDC Outcome ST3.2*

- **SMART Obj. Y1-5:** Between 6/1/24 and 5/31/29, distribute free condoms/safer sex supplies regularly at HAPs, CoEs, SFCC, and annually at Carnival, Pride, and Folsom Street Fair.

CDC 3C: Support harm reduction services (syringe programs, whole-person approach)

SF3.4 Expand access to harm reduction services for PEH and PWU/ID. ***(Responsible: Hanna Hjord)*** This is a companion activity to SF3.2. Expansion of harm reduction services will be done with the same partners, in conjunction with PrEP expansion. *CDC Outcomes ST3.3, IT3.2*

- **SMART Obj. Y1:**
  - By 5/31/25, develop standardized protocols for the Syringe Services Collaborative, which includes programs that are not part of the existing Syringe Access Collaborative (SAC).
  - By 5/31/25, develop a provider referral/information guide to contingency management.
- **SMART Obj. Y2-5:** Between 6/1/25 and 5/31/29, expand syringe access and disposal services to all of the HAP partner agencies.

CDC 3D: Support and promote social marketing campaigns and other communication efforts

SF3.5 Develop and implement a prevention social marketing campaign for the Latine community. ***(Responsible: Nikole Trainor, Aurora Chavez)*** To address the disproportionately high rate of new HIV diagnoses among Latino MSM, and to increase awareness and uptake of HIV prevention (including PrEP/PEP), testing, and treatment services, CHEP will: 1) expand the current "Have Good Sex" campaign with culturally specific messaging and placement to promote the use of free testing and reduce HIV/STI-related stigma, and 2) utilize a collective

impact prevention strategy for Latino MSM in collaboration with the HAPs and other partner programs serving Latino MSM (e.g., AGUILAS, Latino Task Force). *CDC Outcomes ST3.4, IT3.1*

- **SMART Obj. Y1:** By 5/31/25, conduct a landscape analysis of current effective social marketing campaigns for the Latine community/Latino MSM and explore the feasibility of implementing community recommendations for revived social marketing efforts.
- **SMART Obj. Y2-5:** Between 6/1/25 and 5/31/29, incorporate culturally appropriate prevention messages for the Latine community (including monolingual Spanish-speaking) into SFCC's website, social networking sites, and other communication/placement channels.

CDC 3E: Conduct perinatal, maternal, and infant health prevention and surveillance activities

SF3.6 Implement point of care HIV and syphilis testing for people who are or could become pregnant. *(Responsible: Alyson Decker [clinical settings], Thomas Knoble [community settings])* While point of care **(POC)** HIV testing for people who are or could become pregnant is well-established in SF, the recent increases in congenital syphilis cases (6 in 2023) calls for a syndemic approach. Building on existing clinical HIV POC testing infrastructure, public health detailing will be conducted for POC syphilis testing. As of January 2024, all new community HIV/HCV/STI counselors are trained on POC syphilis screening, and CHEP Program Liaisons will provide technical assistance for syphilis testing in the HAPs. HIV Surveillance will continue to monitor perinatal exposure to HIV through routine matches of the HIV case registry and California's birth registry, investigate HIV lab results for perinatally exposed persons, and follow up with medical providers as necessary. *CDC Outcomes ST3.5, IT3.3*

- **SMART Obj. Y1:** By 5/31/25, disseminate public health detailing materials (clinical settings) and community-based screening guidance for POC HIV and syphilis screening for people who are or could become pregnant.
- **SMART Obj. Y2-5:** Between 6/1/25 and 5/31/29, implement POC syphilis public health detailing in clinical settings, and provide technical assistance to the HAPs.

EHE Activities

SFEHE3.7 Implement an annual conference/training for sexual and drug user health frontline workers. *(Responsible: Thomas Knoble)* SFDPH supports a comprehensive suite of workforce development efforts designed to recruit, support, and retain the HIV/HCV/STI workforce. Signature programs include the Community Health Leadership Initiative (CHLI) (training and mentorship for entry-level workers), The Academy (ongoing training series on key topics), the SFDPH HIV/HCV/STI test counselor training, and the Frontline Organizing Group (training, resources, and networking for case managers and other direct service providers). During the project period, SFDPH will address one of the biggest challenges faced by community-based sexual and drug user health providers—how to keep up-to-date on the vast landscape of HIV/HCV/STI and related services. SF's ETE Steering Committee will host an annual conference, with a special focus on newly hired workers, which will include training on the system of care and networking opportunities. CDC Outcomes ST3.1 – ST3.4, IT3.1, IT3.2

- **SMART Obj. Y1:** By 5/31/25, develop a detailed conference plan, including the agenda, speakers/trainers, materials, and logistics.
- **SMART Obj. Y2-5:** Between 6/1/25 and 5/31/29, implement the conference annually.

SFEHE3.8 Explore and implement solutions for maintaining an up-to-date inventory of services, including eligibility criteria, location and hours, and referral procedures.

(Responsible: Thomas Knoble) As soon as any resource guide in SF is developed, it is out of date before it is completed, and the result is fragmentation, duplication, and under-utilization of available HIV/HCV/STI and related services. SF's ETE Steering Committee will explore possible solutions, leveraging the Frontline Organizing Group's listserv to provide updates to changes in services and/or issuing a monthly newsletter to HIV/HCV/STI service providers.

- **SMART Obj. Y1:** By 5/31/25, explore potential solutions and select a solution to pursue.
- **SMART Obj. Y2-5:** Between 6/1/25 and 5/31/29, implement and maintain the solution.

Strategy 4: Respond

SFDPH uses Secure HIV-TRACE to analyze HIV nucleotide sequences reported to HIV Surveillance and to identify molecular clusters at the local level, and conducts time-space analyses to detect diagnoses by neighborhoods or transmission categories that are higher than expected and reach the "alert" level. HIV Surveillance regularly exceeds CDC performance standards for HIV sequence data collection. Findings from HIV-TRACE are shared with the LINCS team for follow-up, building on an established SF culture of using HIV surveillance data for public health action. The SFDPH HIV Surveillance team and LINCS partner closely to rapidly locate and link people in transmission clusters to care and provide testing and linkage to their named partners. The D2C lists routinely used to identify NIC patients are also matched with people identified as being in a transmission cluster, and people on both lists are prioritized for LINCS outreach and intervention. Prioritized populations and networks of concern include: networks with recent ongoing transmission, persons with unsuppressed viral load, vulnerable populations (e.g., PWUD), persons with drug resistant HIV strains, persons with Stage 0 (acute) HIV infection, and persons identified through HIV-TRACE who are also on an existing D2C list.

CDC 4A: Develop and maintain a cross-program CDR leadership and coordination group

SF4.1 Maintain cross-program CDR workgroup to oversee CDR. ***(Responsible: Sharon Pipkin)*** SFDPH will maintain its cross-program CDR workgroup, composed of SFDPH HIV prevention and surveillance leadership, including the HIV/STI Section director and medical director of LINCS, HIV surveillance epidemiologists, a partner services DIS supervisor, and a CHEP branch liaison. This workgroup oversees CDR activities, identifies emerging gaps and inequities in prevention and care, and prioritizes clusters for response. This workgroup is also responsible for annual CDR plan updates. *CDC Outcomes ST4.1, ST4.2, IT4.1*

- **SMART Obj. Y1-5:** Throughout the 5-year grant period, the CDR workgroup will meet quarterly to discuss and oversee CDR activities, including how to prioritize clusters, and review and update the CDR plan annually.

CDC 4B: Communicate and collaborate about CDR

SF4.2 Provide updates to and facilitate discussions with internal SFDPH and community partners on CDR activities. ***(Responsible: Thomas Knoble)*** SFDPH proactively meets with the HIV Community Planning Council **(HCPC)** to keep them informed on how molecular surveillance data is being used. SFDPH takes a transparent and collaborative approach to ensure that the community has the opportunity to learn about and give input on how SFDPH conducts CDR. This is especially important given past and present harms committed by medical and immigration systems, to address perceptions and respond to concerns that such activities could pose risks. Communication and collaboration efforts include presenting CDR activities and updates to the HCPC and participating in the California DPH Cluster Detection and Response

Community Advisory Board. *CDC Outcome IT4.1*

- **SMART Obj. Y1-5:** Throughout the 5-year grant period, SFDPH HIV Surveillance will:
  - Provide a CDR update to the HCPC every 2 years.
  - Collaboratively plan and attend quarterly CDPH CDR Community Advisory Board meetings and coordinate CDR efforts with Los Angeles and California.
  - Participate in workshops and summits to exchange CDR approaches, experiences, and promising practices for effective CDR planning, policies, procedures, and implementations.

CDC 4C: Detect and prioritize clusters

SF4.3: **Use Secure HIV-TRACE to identify clusters and transmitted drug resistance. *(Responsible: Sharon Pipkin)*** SFDPH uses Secure HIV-TRACE to analyze HIV nucleotide sequences and identify molecular clusters at the local level. Surveillance staff also conduct time-space analyses to detect diagnoses by neighborhoods or transmission categories that are higher than expected and reach the "alert" level. Additionally, HIV Surveillance analyzes molecular sequences for transmitted drug resistance. The HIV Surveillance and LINCS teams meet to discuss molecular clusters and prioritize investigations. *CDC Outcomes ST4.1, IT4.1*

- **SMART Obj. Y1-5:** Throughout the 5-year grant period, SFDPH HIV Surveillance will identify molecular clusters (Secure HIV-TRACE) and conduct time-space analyses (CDC program) and bring data to monthly CDR workgroup meetings to determine clusters for prioritization.

CDC 4D: Respond to prioritized clusters and outbreaks to identify and address gaps

SF4.4 Prioritize and respond to clusters and prevent future outbreaks. *(Responsible: Julia Janssen)* The SFDPH HIV Surveillance and LINCS teams will prioritize recent and ongoing transmission clusters of concern for rapid intervention and partner services. These teams will also investigate multi-jurisdictional transmission clusters identified by CDC. Any programmatic gaps or inequities in services received by the persons in transmission clusters will be identified (e.g., missed opportunities for intervention) and this information will be shared with the CDR workgroup and the ETE Steering Committee to address programmatic gaps. HIV Surveillance will continue to submit timely and complete cluster report forms and other cluster data to CDC. *CDC Outcomes ST4.1, ST4.2, IT4.1*

- **SMART Obj. Y1-5:** Throughout the 5-year grant period, SFDPH HIV Surveillance will:
  - Produce monthly lists of people identified as part of a local transmission cluster of interest and prioritized for LINCS investigation.
  - Within 2 weeks of receiving a CDC list of individuals identified as being part of a national priority multi-jurisdictional transmission cluster, share list with LINCS for investigation.
  - Meet with the CDR workgroup and ETE Steering Committee to share information on identified care and service gaps and inequities.

EHE Activities

SFEHE4.5 Build a CDR dashboard to automate analysis and visualize trends. *(Responsible: Sharon Pipkin)* Create a clear, focused, and user-friendly dashboard or data template, to be updated monthly (and automated, if possible), that integrates HIV surveillance and LINCS partner services data. *CDC Outcomes ST4.1, ST4.2, IT4.1*

- **SMART Obj. Y1:** By 5/31/2025, develop a CDR dashboard/template for use by CDR workgroup members and for use during the monthly CDR Workgroup meetings.

- **SMART Obj. Y2-5:** Use the dashboard to guide monthly CDR Workgroup discussions and provide the CDR Workgroup members with access outside of meetings for routine monitoring.

SFEHE4.6 Conduct a CDR outbreak simulation activity to test current CDR outbreak response plans. ***(Responsible: Julia Janssen)*** SFDPH's Reserve for Accelerated Disease Response (RADR) will develop and implement a tabletop or outbreak simulation activity for members of the CDR workgroup and key SFDPH participants. The goal will be to provide practice for those who may be involved, identify clear implementation or planning gaps, and facilitate relationship-building and communication pathways across key stakeholders. *CDC Outcome IT4.1*

- **SMART Obj. Y1:** By 5/31/2025, schedule and plan for an HIV outbreak simulation activity.
- **SMART Obj. Y2-5:** By 5/31/2027, conduct an HIV outbreak simulation activity and develop and distribute an after-action report summarizing gaps and opportunities for improvement.

Strategy 5. Conduct core HIV surveillance activities

The core HIV surveillance program at SFDPH has a long history and commitment to data dissemination and using surveillance data for public health action. SFDPH HIV Surveillance remains open to data sharing, with a strict eye towards data security and confidentiality protocols, to inform and assist our SFDPH, community, and academic partners to advance health outcomes for PWH and target prevention efforts to priority populations. The SFDPH HIV surveillance and prevention programs have an established history of collaboration, support, data integration, and data sharing for public health action. HIV surveillance data informs prevention and drives priorities in SF. For example, HIV Surveillance collects key HIV care and prevention indicators along the HIV care continuum and analyzes them by demographic and geographic characteristics to evaluate the impact of SF's HIV prevention strategy, inform programmatic priorities, identify gaps, and help identify and address SDoH affecting HIV outcomes and disparities. In addition, a unique feature of SFDPH core HIV surveillance activities is PWH medical chart reviews (described below under SF5.1). Chart review data allow SFDPH to evaluate programmatic initiatives such as same-day ART initiation and help track progress on reducing time to ART initiation, time to first HIV care, and time to viral suppression.

CDC 5A: Conduct data collection and reporting

SF5.1 Conduct HIV surveillance data collection and reporting. ***(Responsible: Sharon Pipkin)*** This includes risk factor ascertainment for all HIV cases, including prevalent cases; monthly intrastate de-duplication of HIV cases and 2x/year routine interstate duplicate review (RIDR); working with laboratories and the state Office of AIDS to collect, report to CDC, and ensure completeness of HIV-related laboratory results reporting including all CD4 and viral load test results, all tests from the diagnostic algorithm, and HIV sequence results; collection of and entry into eHARS data on ART use history or clinical evidence suggestive of acute infection and expanded collection of documented negative HIV test results; and prospective medical chart reviews to document vital status, use of additional therapeutic and prophylactic treatments, subsequent opportunistic illnesses, and most recent address for PWH newly diagnosed or deceased within the last 12 months. *CDC Outcomes ST5.1-5.3, IT5.1*

- **SMART Obj. Y1-5:** Throughout the 5-year grant period, SFDPH HIV Surveillance will meet all standards for case ascertainment, death ascertainment, risk factor reporting, duplicate

review, geocoding, laboratory reporting, timeliness, data quality, completeness, and dissemination as detailed in the *Technical Guidance for HIV Surveillance Programs.*

CDC 5B: Maintain data systems and conduct data management activities

SF5.2 Report high-quality HIV surveillance data to CDC ***(Responsible: Sharon Pipkin)*** SFDPH has a demonstrated track record of reporting HIV surveillance data to CDC in required format by required deadlines. HIV epidemiologists perform quality assurance on data elements that are required by CDC and/or are critical for reporting and analysis, and conduct an annual evaluation of the HIV surveillance system. Data from sources such as the Medical Monitoring Project medical record abstraction will be used to examine eHARS data quality and validity. The surveillance program will evaluate the surveillance system 2x/year using CDC Standardized Evaluation Reports and geocoding SAS programs. We work closely with the State Office of AIDS to test and install new CDC version releases of eHARS. Lastly, we collaborate with CDC-funded programs such as the Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement regarding electronic case reporting and electronic laboratory reporting initiatives. *CDC Outcomes ST5.1-5.3, IT5.1*

- **SMART Obj. Y1-5:** Throughout the 5-year grant period, SFDPH will exercise routine quality assurance activities, including QA of eHARS case report form entry of new diagnoses and previously diagnosed persons receiving care in SF, QA of local vital records entered into eHARS, and QA of laboratory reporting as outlined by CDC.

CDC Activity 5C: Conduct data analysis, dissemination and evaluation

SF5.3 Make HIV surveillance data analyses routinely available to SFDPH and community partners. ***(Responsible: Sharon Pipkin)*** HIV Surveillance prepares an annual HIV surveillance report, posts it on the SFDPH website, and presents the data trends to the SF Health Commission, HCPC, Getting to Zero, and other community partners. Data tables and data visualization are used to communicate key information (e.g., maps, graphs over time). Examples of routine analyses include monitoring of HIV drug resistance and HIV genetic diversity and linking geocoded data linked to census and SDoH datasets to guide programmatic efforts and resource allocation. SFDPH uses CDC-developed SAS programs and methods to estimate HIV incidence and prevalence, including undiagnosed HIV infection. All data security, confidentiality, and protections for data sharing are followed and comply with the CDC NCHHSTP data security and confidentiality guidelines. Data-release and data-use policies are in place and kept updated to respond to data requests and provide a secure mechanism to share the minimum relevant HIV data with partners. *CDC Outcomes ST5.3, IT5.1, IT5.3*

- **SMART Obj. Y1-5:**
  - By October 1 each year, publish a community-friendly HIV Epidemiology Annual Report, with comprehensive analysis of trends in key indicators and data visualization.
  - Annually, present HIV surveillance data trends and analyses to the SF Health Commission and HCPC to inform priorities and resource allocation.
  - By November 1 each year, ensure that every member of the HIV Surveillance staff and all other SFDPH staff who have access to or use HIV surveillance data complete the CDC, CDPH, and SFDPH security and confidentially trainings.
  - By September 30 each year, review security and confidentiality guidelines and update policies and procedures to comply with any revisions in guidelines or policies.

CDC Activity 5D: Support data for action and special considerations

SF5.4 Support the use of data for program evaluation and priority setting, public health action, and early identification of emerging issues. ***(Responsible: Sharon Pipkin)*** In addition to activities discussed in SF5.1–5.3, HIV epidemiologists work with HCV and STI epidemiologists to conduct periodic matching of registries and data sets in order to identify syndemic populations. The comprehensive set of variables in the HIV registry, such as up-to-date demographic data and location information, can then be used for HCV and STI LTC and partner services and to update the HCV and STI data sets. Other public health action uses of SFDPH's HIV surveillance data include investigating cases of public health importance (COPHI) within 1 month of notification of case; D2C activities; investigating cases of acute/early HIV infection; cluster detection, prioritization, investigation, and response (see Strategy 4); and support of a Jail Health Services study monitoring post-release viral suppression outcomes. Lastly, core HIV surveillance activities support the Medical Monitoring Project (MMP) through secure sharing and use of contact/location information needed to conduct MMP, and core surveillance data is updated with data obtained through MMP (including current residency, laboratory test results, and transmission risk). *CDC Outcomes IT5.1–IT5.3*

- **SMART Obj. Y1-5:** Throughout the 5-year grant period:
  - Match the HCV case registry to HIV case registry twice and securely share matched cases with the HCV micro-elimination project; and annually, by July 31, match the STI case registry to HIV case registry to evaluate STI morbidity after HIV diagnosis.
  - Annually, after MMP participant data is certified by CDC, use data to update eHARS.

Strategy 6: Support community engagement and HIV planning

With fewer than 200 new SF residents diagnosed with HIV each year and an additional 75 HIV diagnoses of other jurisdictions' residents, getting to zero new infections becomes increasingly challenging, because the populations experiencing new infections tend to be the most impacted by SDoH—root causes that are hard to address. Community engagement to develop outside-the-box, culturally specific approaches to continue to drive down new HIV/HCV/STI infections and overdose is more critical than ever. SF has a rich network of community advisory/policy bodies it consistently relies on for partnership, including the HCPC, the Getting to Zero Consortium, and End Hep C SF. With this new funding cycle, SFDPH plans to strategically expand ongoing pathways for community input and engagement, under the leadership of the full-time ETE Coordinator (Thomas Knoble) and ETE Steering Committee (SF's EHE advisory body).

CDC 6A: Conduct strategic community engagement

SF6.1 Provide mini community grants to engage with key subpopulations. ***(Responsible: Thomas Knoble)*** There is substantial intersectionality across SF's priority populations, and engagement with these specific groups helps guide tailored efforts to reach them. These include Black/African American youth, MSM newcomers to SF (monolingual Spanish-speaking or non-Spanish-speaking), youth experiencing homelessness, and people who engage in sex work. SFDPH will provide at least four small grants to address this need and engage with key subpopulations. *CDC Outcomes ST6.1, IT6.1*

- **SMART Obj. Y1-5:** By 5/31/25, issue at least four mini community grants to provide outreach, health education, and navigation to HAPs, SFCC, and other low-barrier sites for key subpopulations, and support the mini-grant projects throughout the grant period.

SF6.2 Develop an approach to community engagement with youth. ***(Responsible: Health Program Coordinator II, TBH)*** SFDPH will continue to work internally and with youth organizations to engage youth in conversations about sexual and drug user health and include them in policy and program development. SFDPH currently participates in and provides backbone support to the Black/African American Health Initiative STI workgroup, whose goal is to strategize ways to decrease STI rates among Black youth. SFDPH also collaborates with 3rd St. Youth Center and Clinic, provides free condoms to the SF Unified School District (SFUSD), and funds a HAP for transitional aged youth. *CDC Outcomes ST6.1, IT6.1*

- **SMART Obj. Y1:** By 05/31/2025, hire a Youth Engagement Coordinator.
- **SMART Obj. Y2-5:** Create and implement a youth engagement strategy.

CDC 6B: Establish and maintain an HIV Planning Group (HPG)

SF6.3: Continue partnership with HCPC. ***(Responsible: Thomas Knoble)*** HCPC members have expressed a strong interest in moving toward a syndemic approach, as evidenced by their April 2024 endorsement of *SF's 2024-2026 Ending the Epidemics Plan.* SFDPH will continue to engage the HCPC in ETE discussions. To facilitate this approach, the HCPC holds a seat on SF's ETE Steering Committee. *CDC Outcomes ST6.1, ST6.2, IT6.1*

- **SMART Obj. Y1-5:** Throughout the 5-year grant period, CHEP staff will plan and attend monthly full council meetings, co-chair meetings, and steering committee meetings**.**

CDC 6C: Conduct an HIV planning process; develop the Integrated HIV Prevention & Care Plan

SF6.4 Develop a streamlined syndemic and SDoH-focused integrated plan that meets the CDC and HRSA integrated plan requirements, aligns with California's Strategic Plan to End the Epidemics, and serves as SF's Ending the Epidemics Plan. ***(Responsible: Thomas Knoble)*** In 2023, SFDPH worked with the state Office of AIDS and HRSA to allow SF to produce one plan that serves multiple purposes. The first version of this plan was adopted by the HCPC in April 2024, after several rounds of community input and engagement. The plan reflects the work of not only SFDPH, but also the many stakeholders throughout SF who contribute to HIV, HCV, and STI prevention and care. *CDC Outcomes ST6.1, IT6.1*

- **SMART Obj. Y1:** By 5/31/25, work with the HCPC to develop an ongoing process for updating the ETE plan, including incorporating accountability measures.
- **SMART Obj. Y2-5:** Annually starting 6/1/25, update the ETE plan and evaluate progress.

iv. Collaborations

To ensure the communication, collaboration, and coordination needed to deliver an integrated local continuum of services and successfully implement planned activities and strategies, SFDPH actively engages in multiple internal and external partnerships, including a wide array of city, state, and federal collaborations.

Within SFDPH Population Health Division: SFDPH's HIV/HCV/STI surveillance, prevention, and care work is distributed primarily across four branches: 1) Applied Research, Community Health Epidemiology, & Surveillance **(ARCHES)**; 2) Community Health Equity & Promotion **(CHEP)**; 3) Disease Prevention & Control **(DPC)**; and 4) HIV Health Services **(HHS)**. The first three branches are in SFDPH's Population Health Division; a significant portion of their core funding comes from this NOFO. HHS is part of the SF Health Network and oversees Ryan White-funded services.

Within SFDPH and with other city and county agencies: SFDPH will increase collaboration with strategic partners to help address the underlying SDoH that are contributing to the HIV/HCV/STI syndemic: 1) Department of Homelessness and Supportive Housing (homelessness); 2) SFDPH Behavioral Health Services (substance use, mental health); and 3) the Office of Overdose Prevention (substance use). The following key collaborators are funded under this NOFO because of their strategic importance to ending the epidemics: Jail Health Services and Gender Health (HIV navigation), WPIC Street Medicine (serving PEH), and ZSFG Ward 86 (serving PEH).

At the state and federal level: SFDPH collaborates with the California Department of Public Health (CDPH), CDC, HRSA, and SAMHSA. SFDPH is also a member of NASTAD and NCSD. SFDPH partners with the State Office of AIDS (OA) on HIV prevention/care, the State Office of Viral Hepatitis Prevention regarding HCV, the State STD Branch on STI prevention, and the CDPH branch responsible for naloxone distribution. We work closely with CDPH to develop SF's HIV/STI/HCV test counselor training program, which CDPH OA reviews and authorizes. The OA also authorizes SF's syringe programs and provides support and technical assistance as needed.

With community partners: SFDPH has a rich network of healthy collaborations with dozens of SF HIV prevention and care CBOs, as well as collective impact initiatives and provider networks. These collaborators have deep expertise and provide invaluable insight into programs/services:

- **The HIV Community Planning Council** is SF's federally mandated, integrated prevention/care community planning group, with members who are PWH, Ryan White consumers, community members from HIV-affected populations, and SFDPH staff, among others.
- **Getting to Zero** is a collective impact initiative made up of a broad coalition of community members, advocates, CBOs, schools, businesses, government agencies, and interdisciplinary providers working to reduce HIV transmission and HIV-related deaths in SF by 95% by 2025.
- **HIV/AIDS Provider Network (HAPN)** is a coalition of community-based, non-profit agencies providing HIV-related services including case management, mental health/substance use services, housing support, and basic needs services, among others.
- **End Hep C SF** is multi-sector collective impact initiative using evidence-based practices, community wisdom, and creative leveraging of resources to work toward HCV elimination.
- **ETE Steering Committee**. The ETE Steering Committee serves as SFDPH's required EHE advisory group. The Steering Committee has been active since 2020 and includes representatives from HHS, End Hep C SF, HCPC, GTZ, HAPN, SF HIV Frontline Organizing Group, Ward 86, and SFDPH. The SFDPH ETE Coordinator convenes this group monthly to share updates, coordinate services, share best practices, and help guide local ETE efforts.

v. Populations of Focus and Health Disparities

There is a strong overlap in the populations affected by HIV, HCV, and STIs. As successful as SF has been in reducing new **HIV** infections, Black/African Americans, Latine, trans and cis women, PWU/ID, and PEH are less likely to be on PrEP, less likely to achieve viral suppression, and account for a disproportionate number of new HIV diagnoses. Given the high incidence of **STIs** in the city, SFDPH has prioritized STI prevention with: 1) gay, bisexual, and other MSM; 2) adolescents and young adults, particularly those of color; 3) trans persons; and 4) cis women of reproductive age who are at risk of syphilis infection (and therefore newborns with congenital syphilis). Across all four of these populations, Black/African Americans experience higher rates

of STIs than any other group, and are therefore also a prioritized population. For **HCV**, persons less likely to be engaged in or have access to medical care are disproportionately infected and account for the majority of persons living with HCV in SF. These include 1) PWID, 2) PEH and the marginally housed, 3) trans women, 3) Black/African Americans, 4) MSM, and 5) baby boomers.

In addition to the overlap in affected populations, HIV, HCV, and STIs are interconnected, share common root causes, and are similarly impacted by the social, economic, and political landscape. The priority populations of focus for SF's syndemic approach are the five overlapping populations most impacted by HIV/HCV/STIs: **1) Black/African Americans** (served by the Umoja HAP); **2) Latine** (served by the Latine HAP); **3) trans women** (served by the STAHR HAP); **4) people who use drugs, including people who inject drugs** (served by The Lobby HAP); and **5) people experiencing homelessness** (served by The Lobby HAP, Ward 86 POP-UP Clinic, and the proposed mobile HAP). SFCC also serves these populations. Additional HAPs serving transitional age youth and MSM ensure that we maintain the HIV successes we have had to date with these groups, along with equitable access to sexual and drug user health services.

C. APPLICANT EVALUATION AND PERFORMANCE MEASUREMENT PLAN

SFDPH will submit its detailed Evaluation and Performance Measurement Plan (EPMP), including a Data Management Plan (DMP), within the first 6 months of award. Over decades of funding by CDC, SFDPH has demonstrated its ability to successfully collect and analyze CDC-required performance measure data and share evaluation data with stakeholders. This data is routinely used for continuous quality improvement (CQI) of programs and to inform efforts to eliminate health disparities and inequities. Most of the outcome metrics required for this CDC NOFO are already routinely measured by SF's HIV/HCV/STI surveillance programs and included in our annual reports. In instances where CDC metrics are not part of standard annual reports, special data analyses will be conducted, using not only HIV/HCV/STI surveillance data, but also the SFDPH electronic medical record (Epic), community-based program data, and LINCS data.

SFDPH strongly believes that data without action is a missed opportunity. The CDC performance measures will be a key component of our evaluation and CQI processes. SFDPH will report the performance measure findings to CDC according to the reporting schedule, and the findings will be routinely shared with the ETE Steering Committee, which will then work with SFDPH to coordinate appropriate improvements. The ETE Steering Committee will review data quarterly using the Results-Based Accountability (RBA) framework for both EHE and non-EHE activities, identify the "story behind the data" and any root causes of suboptimal outcomes, make recommendations for actions to improve the outcomes, and review the data in subsequent quarters to evaluate the impact of the actions. Partnerships and collaborations are critically important for this CQI process to work. If a performance measure is not trending in the right direction, a shift in approach may be warranted. This is when key partners are brought to the table so that their collective wisdom can bring forward promising and practical solutions. For example, if the data showed that PrEP uptake was lower in a certain group, the ETE Steering Committee might recommend that SFDPH convene the community-based providers serving that group to talk about consistent and culturally specific messaging and how to improve low-barrier access to PrEP for that group. This process puts the solutions in the hands of the people who have on-the-ground expertise and are in a position to implement the programmatic shifts.

In this way, the performance data becomes an integral part of the work, driving CQI.

Data for EHE and non-EHE programs will be tracked separately. The EPMP submitted post-award will describe specific evaluation plans for each EHE activity. Some activities will warrant collecting the same data as for non-EHE programs, such as the mobile HAP, which will collect data on testing, PrEP/PEP, harm reduction, and other services; however, in this example, the mobile HAP data will be "tagged" so that it can be separated out from the larger data set for analysis and evaluation purposes. Other activities will require special focused evaluation plans, such as "SF3.7 Implement an annual conference/training for sexual and drug user health frontline workers." In this example, evaluation for this activity will include post-conference participant feedback surveys and an assessment of the extent to which conference learnings and materials were integrated into practice. Details will be spelled out in the post-award EPMP and DMP. The ETE Steering Committee will be responsible for ensuring the data is used to improve programs, using the RBA method described above.

D. ORGANIZATIONAL CAPACITY OF APPLICANTS TO IMPLEMENT THE APPROACH

Experience and capacity to implement the approach: SFDPH's mission is to protect and promote the health of all San Franciscans. We have two primary divisions (see attached org charts): 1) the Population Health Division (PHD), which includes the ARCHES, CHEP, and DPC Branches (described on p. 16); and 2) the SF Health Network, which includes HHS (which oversees Ryan White funding), the hospitals and clinics, WPIC, behavioral health, and other direct health services. PHD has the administrative infrastructure to support implementation of this project; CHEP has been serving as the lead on CDC HIV NOFOs for decades, including coordinating with the other funded branches and programs within SFDPH, executing MOUs and contracts, and managing the budget. PHD also has strong collaborations with the IT Department in order to manage the physical and technological infrastructure needed to support and maintain all PHD activities, including creating, modifying, and maintaining data systems.

The SFDPH workforce has the experience and cultural competence to lead and implement all the CDC strategies and proposed activities to eliminate HIV and HCV, and turn the curve on STIs. SFDPH strives to ensure our workforce represents the communities we serve. For example, on staff are MSM, including MSM of color; Black/African American and Latine individuals; trans women; PWH; and people with lived experience of homelessness and substance use. Staff have extensive experience in community engagement and program implementation.

SFDPH has a strong track record as a national and international leader in the HIV/HCV/STI field. In 2010, SF was the first in the nation to implement universal offer of ART upon HIV diagnosis, based on the most up-to-date science. It is home to several well-known programs, including the world-renowned Ward 86 and SFCC. End Hep C SF was the first city-focused HCV elimination initiative in the nation. These achievements are reflected in the excellence of the work on the ground. The following are just a few examples: widespread access to testing has led to 97% status awareness among PWH, already higher than the CDC target of 95%; HIV Surveillance regularly exceeds CDC technical guidance standards; and in 2018–2022 LINCS helped achieve a median time from diagnosis to care of 1 day, and from care to ART initiation of 0 days.

This track record of being on the cutting edge and producing exceptional outcomes is evidence that SFDPH has ample capacity to implement and evaluate the proposed core and EHE activities.

For example, LAI ART has already begun to roll out in SF, with Ward 86 leading the charge, creating a jumping off point for further expansion (Activity SFEHE2.4). For Activity SFEHE3.7, the idea for the annual conference on the service landscape was generated in conversations among many thriving workforce development programs and partnerships and therefore already has buy-in and excitement. Furthermore, the ETE Steering Committee has been active since 2020 and is prepared to take on the responsibility of overseeing these new activities.

Capacity building needs: SFDPH will leverage internal and external expertise in HIV/HCV/STI prevention and care, harm reduction, drug user health, and capacity building to train new and existing staff, as well as CBO staff, as part of continuous capacity-building efforts. Training topics include: HIV/HCV/STI skills certification; harm reduction; overdose prevention; STI specimen collection; Clear Impact Results Scorecard; racial humility; trauma-informed systems; syringe access and disposal; and cultural competence working with PEH and PWU/ID. SFDPH will work closely with the CA Prevention Training Center and the Harm Reduction Coalition to provide training and technical assistance for city staff, funded CBOs, and community members.

A major cross-cutting capacity-building need relates to workforce recruitment and retention. Given the extreme economic inequality and unaffordability of SF, SFDPH and its local nonprofit partners have struggled to maintain a workforce with relevant qualifications and experience. This NOFO will help expand and build upon SFDPH's workforce development efforts, including CHLI, The Academy, the Frontline Organizing Group, and others (see Activity SFEHE3.7).

Staffing plan and project management structure (see attached program organizational chart): Principal Investigator (PI) **Nyisha Underwood, MPH** is the Director of the CHEP Branch and a recognized community leader with 20+ years of experience in HIV prevention. She will be accountable for overall planning, implementation, monitoring, and reporting; will oversee the activities assigned to CHEP; and will supervise the ETE Coordinator. **Dr. Stephanie Cohen**, Director of the HIV/STI Prevention Section (DPC Branch), is an internal medicine/infectious disease board-certified public health physician with 18 years of experience in STI/HIV clinical, biomedical, and disease intervention prevention strategies. She will oversee the DPC work funded by this NOFO, including LINCS. **Sharon Pipkin, MPH**, Supervising Epidemiologist, will oversee all HIV surveillance activities. Together, these key staff will ensure fidelity to work and evaluation plans and maintain smooth project implementation. See **Exhibit 4** for additional key staff**.**

Exhibit 4: Staff Accountable for Proposed Activities

Staff	Title	Activities
Erin Antunez	LINCS Manager	2.1, 2.2
Aurora Chavez (in-kind)	GTZ Program Coordinator	3.5
Alyson Decker	ETE Public Health Detailer	1.1, 1.2, 1.5, 2.4, 3.6
Rachel Grinstein (in-kind)	HCV Program Coordinator	2.3
Hanna Hjord (in-kind)	Drug User Health Manager	1.6, 1.7, 2.4, 2.5, 3.2, 3.4
Health Program Coordinator II (TBH)	Youth/MSM Sexual Health Lead	6.3
Thomas Knoble	EHE/ETE Coordinator	2.5, 3.3, 3.6, 3.7, 3.8, 4.2, 6.1, 6.4, 6.5
Julia Janssen	Medical Director, Disease Intervention Services	4.1, 4.3, 4.4, 4.5, 4.6
Sharon Pipkin	Supervising HIV Epidemiologist	5.1, 5.2, 5.3, 5.4

E. WORKPLAN - integrated into the narrative on Strategies 1-6 (see Section B, "Approach")