File No. 190975 Committee Item No. 4
Board Item No. 10

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget & Finance Committee Date October 16, 2019

Board of Supervisors Meeting Date October 22, 2019

Cmte	Board	
☐	☐	Motion
☒	☒	Resolution
☐	☐	Ordinance
☐	☐	Legislative Digest
☐	☐	Budget and Legislative Analyst Report
☐	☐	Youth Commission Report
☐	☐	Introduction Form
☒	☒	Department/Agency Cover Letter and/or Report
☐	☐	MOU
☐	☐	Grant Information Form
☐	☐	Grant Budget
☐	☐	Subcontract Budget
☐	☐	Contract/Agreement
☐	☐	Form 126 – Ethics Commission
☐	☐	Award Letter
☒	☒	Application
☐	☐	Public Correspondence

OTHER (Use back side if additional space is needed)

Completed by: Linda Wong Date October 10, 2019
Completed by: Linda Wong Date October 16, 2019

FILE NO. 190975 RESOLUTION NO.

[Apply for Grant Application - Centers for Disease Control and Prevention - Integrated HIV Surveillance and Prevention Programs for Health Departments - $7,008,377]

Resolution authorizing the Department of Public Health to submit a one-year application for Calendar Year 2020 to continue to receive funding for the Integrated HIV Surveillance and Prevention Programs for Health Departments from the Centers of Disease Control and Prevention, and requesting $7,008,377 in HIV prevention funding for San Francisco from January 1, 2020, through December 31, 2020.

WHEREAS, Administrative Code, Section 10.170.(b), requires Board review of proposed annual or otherwise recurring grant applications of $5,000,000 or more prior to their submission; and

WHEREAS, Department of Public Health (DPH) is currently a recipient of funding for Component A and Component B; and

WHEREAS, Component A contains funds for the "HIV Prevention Project" grant in the amount of $4,199,037 and the "HIV Surveillance" grant in the amount of $809,294 and Component B contains funds in the amount of $2,000,000 from the Centers of Disease Control and Prevention, Department of Health and Human Services for Calendar Year 2019; and

WHEREAS, For this round of funding, DPH was instructed by the Centers for Disease Control and Prevention to submit a one-year application request in the amount of $7,008,377; and

WHEREAS, DPH utilizes these funds to support epidemiological activities required to support this system of HIV surveillance and prevention as well as direct services provided by the Department, or those subcontracted to qualified contractors selected through Requests for Proposals; and

WHEREAS, The required strategies and activities for the Integrated HIV Surveillance and Prevention Programs for Health Departments grant are the following: 1) systematically collect, analyze, interpret and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health intervention and evaluate public health response; and 2) identify persons with HIV infection and uninfected persons at risk for HIV infection; 3) develop, maintain and implement plan to respond to HIV transmission clusters and outbreaks; 4) provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection; 5) provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection; 6) conduct community-level HIV prevention activities; 7) develop partnerships to conduct integrated HIV prevention and care planning; 8) implement structural strategies to support and facilitate HIV surveillance and prevention; 9) conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention and care activities; 10) build capacity for conducting effective HIV program activities, epidemiologic science and geocoding; and 11) conduct a Demonstration Project (Component B) to improve HIV/HCV-related outcomes for people who are homeless and who use drugs; and

WHEREAS, Ordinance No. 265-05 requires that City Departments submit applications for approval at least 60 days prior to the grant deadline for review and approval; and

WHEREAS, The Centers for Disease Control and Prevention released the application announcement on July 25, 2019, and due on September 16, 2019 allowing 36 business days for the entire process; and

WHEREAS, In the interest of timeliness, SFDPH is making this request for approval by submitting last year's application for the Integrated HIV Surveillance and Prevention Programs for Health Departments grant funding from the Centers for Disease Control and Prevention, also including supporting documents as required, all of which are on file with the Clerk of the

Board of Supervisors in File No. 190975, which is hereby declared to be part of the Resolution as if set forth fully herein; and now, therefore, be it

RESOLVED, That the Board of Supervisors hereby approves SFDPH application submission to the Centers for Disease Control and Prevention for the "Integrated HIV Surveillance and Prevention Programs for Health Departments" grant for funding in 2020, to be submitted no later than September 16, 2019.

Recommended:

Grant Colfax, M.D.
Director of Health

Department of Health & Human Services
Centers for Disease Control and Prevention (CDC)
Integrated HIV Surveillance and Prevention Programs for Health Departments (CDC)

REQUIRED INFORMATION, PER SF ADMINISTRATIVE CODE SEC. 10.170(B)

Funding Source's Grant Criteria

The San Francisco Department of Public Health is currently a recipient of the CDC grant PS18-1802 from the Centers for Disease Control and Prevention (CDC), Department of Health & Human Services. The award contains funding for Component A and Component B. Component A contains HIV Prevention Project grant in the amount of $4,199,037 & HIV Surveillance grant $809,294 for and Component B in the amount of $2,000,000. The grant is awarded to the City and County of San Francisco.

Applications for PS18-1802 may be submitted by State, local, and/or territorial health departments currently funded under funding opportunity announcements PS18-1802.

Department's Most Recent Grant Application Materials

Year 2020 application announcement for the Integrated HIV Surveillance and Prevention Programs for Health Departments grant had been issued to the Department on July 25, 2019 and due on September 16, 2019. Please see Attachment A for the latest application materials dated August 31, 2018 for calendar year 2019.

Anticipated Funding Categories That The Department Will Establish In The Subsequent Request For Proposals (RFPs) Process

The funds are awarded to the Department on an annual basis to cover an integrated HIV Surveillance and Prevention Program for San Francisco residents. The funds are utilized to support epidemiological activities required to support this system of HIV surveillance and prevention as well as direct services provided by the Department, or those subcontracted to qualified contractors selected through RFP.

Required Strategies and Activities of PS18-1802 are 1) systematically collect, analyze, interpret and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health intervention and evaluate public health response; 2) identify persons with HIV infection and uninfected persons at risk for HIV infection; 3) develop, maintain and implement plan to respond to HIV transmission clusters and outbreaks; 4) provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection; 5) provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection; 6) conduct community-level HIV prevention activities; 7) develop partnerships to conduct integrated HIV prevention and care planning; 8) implement structural strategies to support and facilitate HIV surveillance and prevention; 9) conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention and care activities and 10) build capacity for conducting effective HIV program activities, epidemiologic science and geocoding.

11) conduct a Demonstration Project (Component B) to improve HIV/HCV-related outcomes for people who are homeless and who use drugs.

Comments From Any Relevant Citizen Advisory Body

The HIV Community Planning Council (HCPC) works with the health department to write the Prevention Plan, upon which the application for funding is based and all RFPs are based. A list of the HCPC members is included in Attachment B.

Attachment A

Table Of Contents

Applicant:	San Francisco Department of Public Health
Application Number:	NU62PS2018003083
Project Title:	San Francisco Dept of Public Health High Impact Prevention
Status:	Submitted

Online Forms

Additional Information to be Submitted

1. SF-424 Application for Federal Assistance Version 2
2. SF-424A Budget Information - Non-Construction
3. SF-424B Assurances - Non-Construction
4. SF-LLL Disclosure of Lobbying Activities
5. Project Abstract Summary
   - (Upload #1): Abstract
6. Change Grantee Information
7. Change Project Director
8. Key Personnel
9. Project Period Revision
10. Miscellaneous
    - (Upload #2): Indirect Cost Memo
    - (Upload #3): Assurance of Compliance
    - (Upload #4): Certificate of Compliance
    - (Upload #5): Project Narrative
    - (Upload #6): Combined Jurisdictional EPMP
    - (Upload #7): PS18-1802 Component A Budget Justification
    - (Upload #8): PS18-1802 Component B Budget Justification

Note: Upload document(s) printed in order after online forms.

OMB Approval No. 4040-0006
Expiration Date: 01/31/2019

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. PS18-1802.NU62 Integra	93.940			$4,199,083.00		$4,199,083.00
2. PS18-1802.NU62 Integra	93.940			$809,294.00		$809,294.00
3. PS18-1802.NU62 Integra	93.940			$2,000,000.00		$2,000,000.00
4. PS18-1802.NU62 Integra						
5. Totals				$7,008,377.00		$7,008,377.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) PS18-1802.NU62 Integrate	(2) PS18-1802.NU62 Integrate	(3) grated HIV Component B P	(4) egrated HIV Prevention P	(5)
a. Personnel	$1,106,801.00	$389,694.00	$756,148.00		$2,252,643.00
b. Fringe Benefits	$498,059.00	$163,672.00	$297,086.00		$958,817.00
c. Travel	$12,784.00	$13,226.00	$7,458.00		$33,468.00
d. Equipment					
e. Supplies	$17,000.00	$1,680.00	$3,788.00		$22,468.00
f. Contractual	$2,244,739.00	$117,401.00	$689,152.00		$3,051,292.00
g. Construction					
h. Other	$43,000.00	$26,197.00	$57,331.00		$126,528.00
i. Total Direct Charges *(sum of 6a-6h)*	$3,922,383.00	$711,870.00	$1,810,963.00		$6,445,216.00
j. Indirect Charges	$276,700.00	$97,424.00	$189,037.00		$563,161.00
k. TOTALS *(sum of 6i and 6j)*	$4,199,083.00	$809,294.00	$2,000,000.00		$7,008,377.00
7. Program Income					

1470

SECTION C - NON-FEDERAL RESOURCES				
(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8				
9.				
10.				
11.				
12. TOTAL *(sum of lines 8-11)*				

SECTION D - FORECASTED CASH NEEDS					
	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$7,008,377.00	$1,752,094.25	$1,752,094.25	$1,752,094.25	$1,752,094.25
14. Non-Federal					
15. TOTAL *(sum of lines 13 and 14)*	$7,008,377.00	$1,752,094.25	$1,752,094.25	$1,752,094.25	$1,752,094.25

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT				
(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16.				
17.				
18.				
19.				
20. TOTAL *(sum of lines 16-19)*				

SECTION F - OTHER BUDGET INFORMATION	
21. Direct Charges: 6445216	22. Indirect Charges: 563161
23. Remarks: 25% of Salaries	

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Standard Form 424A (Rev. 7-97) Page 2

Change Grantee Info

Grantee Name:	San Francisco Department of Public Health
Country:	UNITED STATES
Address:	101 Grove St 25 Van Ness Ave. Suite 500
City:	San Francisco
State:	CA
Zip:	94102-4505

OMB Number: 0980-0204
Expiration Date: 04/30/2015

Project Abstract Summary

Program Announcement (CFDA)

* Program Announcement (Funding Opportunity Number)
Not Applicable

* Closing Date

* Applicant Name
San Francisco Department of Public Health

* Length of Proposed Project 12

Application Control No.

Federal Share Requested (for each year)

* Federal Share 1st Year	* Federal Share 2nd Year	* Federal Share 3rd Year
$ 7,008,377.00	$ 0.00	$ 0.00
*** Federal Share 4th Year**	*** Federal Share 5th Year**	
$ 0.00	$ 0.00	

Non-Federal Share Requested (for each year)

* Non-Federal Share 1st Year	* Non-Federal Share 2nd Year	* Non-Federal Share 3rd Year
$ 0.00	$ 0.00	$ 0.00
*** Non-Federal Share 4th Year**	*** Non-Federal Share 5th Year**	
$ 0.00	$ 0.00	

* Project Title
San Francisco Dept of Public Health High Impact Prevention

OMB Number: 0980-0204
Expiration Date: 04/30/2015

Project Abstract Summary

* Project Summary

* Estimated number of people to be served as a result of the award of this grant. 0

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
[b] a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	[b] a. bid/offer/application b. initial award c. post-award	[a] a. initial filing b. material change

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
☒ Prime ☐ Subawardee Tier _____, *if known:* n/a n/a n/a **Congressional District,** *if known:*	
6. Federal Department/Agency: Department of Tranportation	**7. Federal Program Name/Description:** National Center for HIV/AIDS, Viral Hepa CFDA Number, *if applicable:* 93.940
8. Federal Action Number, *if known:*	**9. Award Amount,** *if known:* $
10. a. Name and Address of Lobbying Registrant *(if individual, last name, first name, MI):* n/a, n/a n.	**b. Individuals Performing Services** *(including address if different from No. 10a) (if individual, last name, first name, MI):* n/a, n/a
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Mr. Sajid Shaikh Print Name: Aragon, Tomas Title: Director of Population Health Divison Telephone No: _____ Date: 08/31/2018.

OMB Approval No.: 4040-0007
Expiration Date: 06/30/2014

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681- 1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93- 205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Tomas Aragon	Director of Population Health Division
* APPLICATION ORGANIZATION	* DATE SUBMITTED
San Francisco Department of Public Health	08/31/2018

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Key Personnel

Name	Position Title	Annual Salary	No.Months Budget	% Time	Fed Amount	Non-Fed Amount	Total Amount Requested
Tomas Aragon	Director of Population Health	314,163.00	12.00		0.00	0.00	0.00

OMB Number: 4040-0004

Expiration Date: 08/31/2016

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☐ New	
☒ Application	☒ Continuation	* Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
08/31/2018	

5a. Federal Entity Identifier:	* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	08/31/2018	7. State Application Identifier:	

8. APPLICANT INFORMATION:

* a. Legal Name:	San Francisco Department of Public Health

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
1946000417A8	103717336

d. Address:

* Street1:	101 Grove St
Street2:	
* City:	San Francisco
County:	
* State:	California
Province:	
* Country:	UNITED STATES
* Zip / Postal Code:	94102-4505

e. Organizational Unit:

Department Name:	Division Name:
25 Van Ness Ave. Suite 500	

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:		* First Name:	Tracey
Middle Name:			
* Last Name:	Packer		
Suffix:			

Title:	Director of Community Health Equity & Promoti

Organizational Affiliation:

* Telephone Number:	415-437-6223	Fax Number:	415-431-7154

* Email:	tracey.packer@sfdph.org

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

CDC-National Center for HIV/AIDS, Viral Hepa

11. Catalog of Federal Domestic Assistance Number:

93.940

CFDA Title:

HIV Prevention Activities_Health Department Based

*** 12. Funding Opportunity Number:**

Not Applicable

* Title:

Not Applicable

13. Competition Identification Number:

Not Applicable

Title:

Not Applicable

14. Areas Affected by Project (Cities, Counties, States, etc.):

*** 15. Descriptive Title of Applicant's Project:**

San Francisco Dept of Public Health High Impact Prevention

Attach supporting documents as specified in agency instructions.

OMB Number: 4040-0004

Expiration Date: 08/31/2016

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

* a. Applicant: 12

* b. Program/Project: 12

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:

* a. Start Date: 01/01/2019

* b. End Date: 12/31/2019

18. Estimated Funding ($):

* a. Federal	7008377
* b. Applicant	0
* c. State	0
* d. Local	0
* e. Other	0
* f. Program Income	0
* g. TOTAL	7008377

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

[ ] a. This application was made available to the State under the Executive Order 12372 Process for review on

[X] b. Program is subject to E.O. 12372 but has not been selected by the State for review.

[ ] c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

[ ] Yes [X] No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

[X] ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:	
* First Name:	Tomas
Middle Name:	
* Last Name:	Aragon
Suffix:	
* Title:	Director of Population Health Division
* Telephone Number:	415-554-2898
Fax Number:	415-554-2710
* Email:	Tomas.aragon@sfdph.org
* Signature of Authorized Representative:	Mr. Sajid Shaikh
* Date Signed:	08/31/2018

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Standard Form 424 (Revised 10/2005)

Prescribed by OMB Circular A-102

Application for Federal Assistance SF-424 Version 02

*** Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

Upload #1

Applicant:	San Francisco Department of Public Health
Application Number:	NU62PS2018003083
Project Title:	San Francisco Dept of Public Health High Impact Prevention
Status:	Submitted
Document Title:	Abstract

Abstract

In 2013 SF launched the "Getting to Zero SF" initiative 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; however, surveillance data show that significant disparities in linkage, retention, and viral suppression among people living with HIV remain. African-Americans and Latinos, trans and cis-gender women, people who inject drugs, and people experiencing homelessness are less likely to be virally suppressed. In terms of new diagnoses, people of color make up an increasingly higher percentage of new diagnoses. SFDPH's Component A proposal expands on the Department of Public Health's (SFDPH's) 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" to Outreach, Prevention and Treatment) – an innovative, broadly collaborative project serving those whose lives are deeply affected by the social determinants of health, such as people experiencing homelessness. We must do a better job with these groups if we hope to "get to zero," for all SF populations.

Clients Served: 15,000

Upload #2

Applicant:	San Francisco Department of Public Health
Application Number:	NU62PS2018003083
Project Title:	San Francisco Dept of Public Health High Impact Prevention
Status:	Submitted
Document Title:	Indirect Cost Memo

DATE: February 12, 2018

TO: Grants Managers
Naveena Bobba
Jennifer Boffi

FROM: Drew Murrell
Finance Manager

RE: FY18-19 Overhead Costs

Effective immediately, the Indirect Cost rate for Population Health & Prevention-Public Health Division is 25.00% of salaries. This rate was based on FY 2015-16 costs and includes the COWCAP allocation (FY 17-18) reported in the OMB A-87 Cost Allocation Plan. Public Health Division Grant Managers should use 25.00% indirect cost rate on all current grants and new or renewal grant applications, unless the grantor has specified a maximum rate lower than 25.00% .

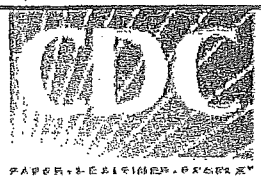
Other Divisions in the Health Department should add the following costs to their divisions' internal indirect costs in order to reflect total indirect costs:

	Amount
Mental Health	5,216,680
Substance Abuse	1,157,921
Primary Care	4,580,287
Health at Home	615,957
Jail Health	1,363,697
Laguna Honda Hospital	15,076,704
ZSFG	38,842,994

cc: Christine Siador
Stephanie Cushing
Susan Philip
Joshua Nossiter

Upload #3

Applicant:	San Francisco Department of Public Health
Application Number:	NU62PS2018003083
Project Title:	San Francisco Dept of Public Health High Impact Prevention
Status:	Submitted
Document Title:	Assurance of Compliance



ASSURANCE OF COMPLIANCE
with the
"PROGRAM GUIDANCE ON THE REVIEW OF HIV-RELATED EDUCATIONAL AND INFORMATIONAL MATERIALS FOR CDC ASSISTANCE PROGRAMS"

By signing and submitting this form, we agree to comply with the specifications set forth in the "Program Guidance on the Review of HIV-Related Educational and Informational Materials for CDC Assistance Programs," revised as of June 2016.

We agree that all written materials, audio visual materials, and pictorials, including social marketing and advertising materials, educational materials, social media communications (e.g., Facebook, twitter) and other electronic communications, such as internet/webpages will be submitted to a Program Review Panel. The Panel shall be composed of no less than five persons representing a reasonable cross-section of the general population; but which is not drawn predominantly from the intended audience. See additional requirements in the referenced program guidance, especially section 2 (c-d) (1-5) regarding composition of Panel.

The Program Review Panel, guided by the CDC Basic Principles, set forth in 1(a-g), will review and approve all applicable materials before their distribution and use in any activities funded in any part with CDC assistance funds.

Following are the names, occupations, and organizational affiliations of the proposed panel members: (If panel has more members than can be shown here, please indicate additional members on the reverse side.)

CDC 0.1113 (E), Rev. 6/2016, CDC Adobe Acrobat DC Electronic Version, 6/2016

NAME	OCCUPATION	AFFILIATION
Dale Gluth	Evaluation/QI Specialist	Office of Equity and Quality Improvement
Celia Gomez	Substance Use Specialist	Community Member
David Gonzalez	Unemployed	Community Member
Travis Tuohey	Assistant Director	CBHS LEGACY Program
Oscar Macias	Health Program Coordinator I	Community Health Equity & Promotion Branch (Health Department Representative)

Applicant/Recipient Name: San Francisco Department of Public Health	**Grant Number (If Known):** 93.940 (CFDA) PS18-1802
Signature: Project Director Tracey Packer	**Signature: Authorized Business Official** Christine Siador DocuSigned by: Christine Siador 96E9E9598E77423...
Date: 8/28/18	**Date:** 8/29/2018 | 8:25:06 PDT

Upload #4

Applicant:	San Francisco Department of Public Health
Application Number:	NU62PS2018003083
Project Title:	San Francisco Dept of Public Health High Impact Prevention
Status:	Submitted
Document Title:	Certificate of Compliance

ATTACHMENT H:
Certification of Compliance Statement

CERTIFICATION OF COMPLIANCE WITH THE NCHHSTP DATA SECURITY AND CONFIDENTIALITY STANDARDS AND DESIGNATION OF OVERALL RESPONSIBLE PARTY (ORP)

We certify our compliance with the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention's (NCHHSTP) Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011). We acknowledge that all standards included in the NCHHSTP Data Security and Confidentiality Guidelines have been implemented for the HIV surveillance and prevention program funded by FOA PS18-1802 unless otherwise justified in an attachment to this statement. We acknowledge that all standards included in the NCHHSTP Data Security and Confidentiality Guidelines have been implemented for programs with which we share data, including NCHHSTP programs unless otherwise justified in an attachment to this statement. We agree to apply the standards to all local/state staff and contractors funded through NCHHSTP that have access to and/or maintain confidential, personally identifiable public health data. We ensure all sites where applicable public health data are maintained are informed about the standards. Documentation of required local data policies and procedures is on file with the Overall Responsible Party(s) and available upon request.

Please check all that apply:

- ☑ In full compliance with the Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011) for HIV surveillance, prevention, and other NCHHSTP funded programs; there are no attachments to this statement.

- ☐ In full compliance with the Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011) for either HIV surveillance or HIV prevention only (not both) and a justification is provided in an attachment to this statement.

- ☐ Pursuing compliance with the Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011) for HIV surveillance and prevention programs; and a justification is provided in an attachment to this statement.

- ☐ Pursuing compliance with the Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011) for other NCHHSTP funded programs to facilitate sharing and use of surveillance data and a justification is provided in an attachment to this statement.

Name(s), title, and organizational affiliation of the proposed ORP(s)

ORP Name	Title	Affiliation
Tomás Aragón	Director, Population Health	Principle Investigator - San Francisco Department of Public Health

Applicant/Grantee Name San Francisco Department of Public Health	Grant/Cooperative Agreement Number 93.940 (CFDA) PS18-1802
Signature Overall Responsible Party (ORP) Tomás Aragón Tomás Aragón	Date 8/28/18
Signature Authorized Business Official Christine Siador Christine Siador	Date 8-28-18
Signature Principle Investigator (s) Tomás Aragón Tomás Aragón	Date 8/28/18

Upload #5

Applicant:	San Francisco Department of Public Health
Application Number:	NU62PS2018003083
Project Title:	San Francisco Dept of Public Health High Impact Prevention
Status:	Submitted
Document Title:	Project Narrative

San Francisco Department of Public Health
Greg Wagner
Acting Director of Health

City and County of San Francisco
London N. Breed
Mayor

Carla Alexander-Pender,
Darrin Brown,
Benjamin Laffoon

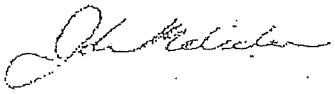
John Melichar
San Francisco Department of Public Health
25 Van Ness, Ste. 500
San Francisco CA 94102

Hello CDC Team for PS18-1802 Component A in San Francisco,

San Francisco is pleased to submit its first Annual Performance Report (APR) and Evaluation Performance Measurement Plan (EPMP) for PS18-1802, Component A. These documents capture San Francisco's HIV prevention and epidemiology efforts on a high level and will inform the deeper discussions we have in our quarterly and monthly calls with our CDC Team.

Currently San Francisco is in planning mode, reviewing our overall HIV prevention plan, strategies and needs, and we will release a new RFP in early 2019 soliciting new services based on what we learn. The EPMP is a plan and as such is a living document that we will update as our knowledge increases and our needs change. The 2019 APR will differ significantly from what we provide for 2018. Wherever "no changes anticipated" is written in the APR or EPMP, please understand that means we expect services to remain the same for the remainder of 2018, but that we expect significant shifts in 2019.

We look forward to sharing our plans as they develop and hearing your input on our current status.



John Melichar
Health Program Coordinator
PS18-1802 Component A APR and EPMP Report Coordinator

PROJECT NARRATIVE

SECTION I: COMPONENT A: Core Strategies and Activities for Integrated HIV Surveillance and Prevention

Strategy 1. Systematic collection, analysis, interpretation, and dissemination of HIV data for surveillance and prevention program monitoring and evaluation

Activity 1.A. HIV surveillance
Collect HIV case data, including (but not limited to) data on CD4 cell count, HIV viral load, molecular laboratory test results, vital status, and geocoding.

- 1.1. Improved completeness, timeliness, and quality of HIV surveillance data
- 1.2. Improved monitoring of trends in HIV infection
- 1.5. Increased ability to describe the geographic distribution of HIV and understand the social determinants of health in relation to HIV and HIV-related health disparities

Successes:
SFDPH continues to conduct ongoing HIV case surveillance activities including collecting CD4, viral load, molecular laboratory test results, vital status and geocoding. Data are reviewed and evaluated for completeness, timeliness and quality on an ongoing basis. Preliminary evaluation outcomes for 2017 diagnoses find that 100% of cases are entered without critical error or required fields missing, 95% have complete risk factor ascertainment, 53% of cases have a lab-documented negative HIV test and 85% have a CD4/viral load test within one month of diagnosis.

HIV surveillance data is analyzed and shared with HIV prevention programs to identify specific populations at risk for HIV, and living with both diagnosed and undiagnosed HIV, and to assess trends and disparities along the HIV Care Continuum. The data is shared with clinical and community-based providers, San Francisco's integrated HIV prevention and care planning group (the HIV Community Planning Council or HCPC), the SF Health Commission and the SF Getting to Zero Consortium and others. In addition, HIV surveillance data is widely disseminated in annual reports, published manuscripts, at scientific conferences and with colleagues both nationally and internationally. Using a data-driven approach, HIV prevention strategies are adjusted to align with the most current epidemiologic trends, develop policy, allocate resources and plan and implement services.

San Francisco cases are geocoded and this data is used to describe the geographic distribution of HIV and understand the social determinants of health including housing status and poverty. In addition, San Francisco started using HIV-TRACE in January 2018 to monitor HIV transmission clusters. Since then, we have been monitoring transmission clusters and have created an algorithm to prioritize identified clusters for investigation based on geographic location of cases (including homeless encampments) recency of diagnosis, housing status, race, injection drug use and viral suppression. We are working closely with the SFDPH Linkage Integration Navigation, Comprehensive Services (LINCS) team to continually modify the algorithm to identify persons most in need of assistance linking or re-linking to care, establishing viral suppression or reaching out to their sexual or needle-sharing partners.

Challenges: None noted.

Anticipated Changes: None noted.

Activity 1.B. HIV prevention program monitoring & evaluation
Collect data to monitor and evaluate HIV prevention programs

- 1.6. Improved completeness, timeliness, and quality of HIV prevention program data (Outcome)

Successes:
HIV testing is the only program activity funded under PS18-1802 and the funded sites, SFDPH City Clinic and Jail Health Services, are SFDPH clinical sites which collect truncated sets of data.

EvaluationWeb is being used as the repository of and reporting system for HIV testing data for both 18-1802 funded and non-18-1802 funded programs. Some non-funded agencies key in HIV testing data, others upload. SFDPH City Clinic enters data into its own system, ISCHTR, Jail Health Services enters its data into the SFDPH electronic medical record. In both cases, these datasets are truncated and ARCHES uploads them into EvalWeb biannually. This system is solidly in place and functional over the life of PS12-1201 and will continue into PS18-1802.

For agencies and programs not funded by PS18-1802, EvalWeb is also used as the database for HIV testing, in some cases uploaded and keyed in in others. This includes current local questions on PrEP that are being evaluated for their compatibility with 18-1802 fields being used in 2019. Some agencies also use EvalWeb for non-HIV testing data or have their own data collection and reporting

processes in place.

Challenges: None noted.

Anticipated Changes:
San Francisco is working with Luther Consulting on implementing the updated variable set for EvalWeb testing data and different options are being discussed. SFDPH does not anticipate any challenges and expects to be prepared for the January 1, 2019 EvalWeb rollout.

Evaluation and Performance Measurement Plan Updates

1. Please submit your updated Evaluation and Performance Measurement Plan (EPMP) for Year 1 utilizing the current template to the PS18-1802 mailbox (ps18-1802@cdc.gov) by the due date, August 31, 2018.

Strategy 2. Identification of persons with HIV infection and uninfected persons at risk for HIV infection

Activity 2.A. Conduct HIV testing

- 2.1. Increased HIV testing among persons at risk for HIV infection (Output)
- 2.2. Increased number of persons living with HIV infection who are aware of their HIV status (Outcome)
- 2.3. Increased identification of HIV-negative persons at risk for HIV infection (Output)

Successes:
SFDPH continues to support high-volume, targeted testing to high-prevalence populations (MSM, PWID, and trans women) and casts a wide net to reach populations not yet reached with the current testing strategy. Testing is incorporated into holistic "Special Projects" for prioritized populations i.e. AAMSM, Latino MSM, transwomen as well as integrated into programs providing substance use treatment.

Using the CDC provided SAS program, we estimate that 6% of persons living with HIV in San Francisco are unaware of their infection. 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 has reinvigorated medically based opt-out HIV testing and work to find late testers earlier in their course of infection as well as the estimated 6% of PLWH who are unaware of their infection.

Challenges: None noted.

Anticipated Changes: No changes anticipated.

Activity 2.B. Conduct HIV partner services

- 2.4. Increased participation in HIV partner services among persons with diagnosed HIV infection, identified through PS18-1802-funded testing (Outcome)
- 2.5. Increased participation in HIV partner services among persons with diagnosed HIV infection, identified throughout the jurisdiction (Outcome)
- 2.6. Increased partner elicitation through HIV partner services interviews of index patients with newly diagnosed HIV infection (Outcome)
- 2.7. Increased notification and HIV testing of partners identified through HIV partner services (Output)
- 2.8. Increased number of partners living with HIV infection who are aware of their HIV status (Outcome)
- 2.9. Improved laboratory reporting to HIV surveillance (Output)

Successes:
Partner services provided for persons diagnosed with HIV-infection are not stratified by funding sources and efforts to increase participation are the same for all clients. Partners services are offered to all clients newly diagnosed with HIV as well as clients diagnosed with an STI. Partner services are also offered to clients who are previously diagnosed with priority given to clients who are identified as being out of care.

Efforts to increase participation include identifying partners who have been prioritized by an algorithm that includes being out of care, homeless, associated with a cluster.

Challenges: None noted.

Anticipated Changes: No anticipated changes.

1. Provide information on Partner Services for newly diagnosed index patients for the reporting period. **See Table in Appendix A.**

Strategy 3. Development, maintenance, and implementation of plans to respond to HIV transmission clusters and outbreaks

Activity 3.A. Identify and investigate HIV transmission clusters and outbreaks

- 3.1. Improved early identification and investigation of HIV transmission clusters and outbreaks (Outcome)

Successes:
SFDPH has implemented Secure HIV-TRACE to analyze HIV nucleotide sequences and identify molecular clusters at the local level. We have been sharing information from HIV-TRACE with LINCS for cluster investigation and will continue to utilize the services of the LINCS navigators to reach out to persons needing assistance re-linking to care and/or who are identified as being part of

growing transmission cluster to interrupt further transmission. In addition, we have a plan to meet with Project Inform, a community think tank, in September 2018 to develop strategies and communication plans to engage the community, building knowledge and support for these activities.

Challenges: None noted.

Anticipated Changes: None anticipated.

Activity 3.B. Rapidly respond to and intervene in HIV transmission clusters and outbreaks

- 3.2. Improved response to HIV transmission clusters and outbreaks (Outcome)

Successes:
SFDPH prioritizes and investigates transmission clusters that are concerning for recent and ongoing transmission. For newly identified HIV-positive cluster members, clients are prioritized for rapid intervention and partner services. PLWH in transmission clusters who are not virally suppressed are evaluated for assistance from the LINCS team for engagement in care services.

Challenges: None anticipated.

Anticipated Changes: None anticipated.

Activity 3.C. Maintain outbreak identification and response plan

- 3.3. Improved plan and policies to respond to and contain HIV outbreaks (Outcome)

Successes:
If a large, rapidly growing transmission cluster is identified in San Francisco, we will utilize the plans for outbreak investigation from the SFDPH emergency preparedness team for disease outbreak investigation. SFPDH has an extensive infectious disease emergency response plan involving multiple branches within the SFDPH Population Health Division available to respond and assist the LINCS team (who would be the first responders in an HIV outbreak) if additional resources and/or staff are needed. As part of the response, we will confirm the cluster, identify and characterize risk networks involved with the cluster, and identify communities who are in need of targeted testing, prevention efforts, and linkage to care. SFDPH staff regularly discuss all-hazards response plans with other jurisdictions throughout the San Francisco Bay Area and the state. We will utilize existing health alert communication systems in order to communicate with other public health professionals as needed. As part of our ongoing public health emergency preparedness and response plans, we are

assessing and evaluating jurisdictional capacity for cluster detection and response involving epidemiological investigations and surveillance on an ongoing basis.

Challenges: None anticipated.

Anticipated Changes:
We will modify the existing disease emergency response plan to specifically address an HIV transmission cluster investigation by August 2019.

1. Did you identify any emerging HIV infections in populations/areas within the jurisdiction, as a result of having an HIV outbreak response plan in place? ☐ Yes ☒ No
   If yes, please provide a brief update?

2. Did you identify any emerging HIV infections in populations/areas within the jurisdiction, as a result of participating in cluster detection activities? ☐ Yes ☒ No
   If yes, please provide a brief update on any follow-up prevention activities (e.g., Partner Services) to support this activity?

Strategy 4. Comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH)

Activity 4.A. Provide linkage to HIV medical care for persons with newly and previously diagnosed HIV infection identified through HIV testing and partner services
- 4.1. Increased linkage to and retention in HIV medical care among PLWH (Outcome)

Successes:
SFDPH has strengthened, streamlined, and addressed 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 includes 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.

Challenges: None noted.

Anticipated Changes: No changes anticipated.

Activity 4.B. Conduct data-to-care activities
- Identify persons with previously diagnosed HIV infection who are not in care through data-to- care activities
- Provide linkage to, re-engagement in, and retention in HIV medical care services for persons with previously diagnosed HIV infection who are not in care identified through data-to-care activities

Successes:
SFDPH HIV surveillance has provided surveillance-generated NIC lists to the LINCS Team, of HIV-positive individuals potentially not in care or other prioritized groups, such as persons experiencing viral failure, those with early infection, and those in transmission clusters. In addition, HIV surveillance data is used to match clinic-generated NIC lists to eHARS to confirm out of care status of patients prior to assignment by LINCS.

Challenges: Many of the patients identified as NIC are unable to locate.

Anticipated Changes:
Through a continually quality improvement focus, we modify the NIC inclusion criteria to maximize the likelihood that patients living in San Francisco are identified for LINCS assignment and assistance.

Activity 4.C. Promote early ART initiation
Activity 4.D. Support medication adherence

- 4.4. Increased provision of ART medication adherence support for PLWH (Output)

Successes:
Through PrIDE funding, SFDPH has implemented public health detailing to educate medical providers and frontline workers about RAPID as well as LINCS and PrEP. The San Francisco AIDS Foundation works closely with UCSF Ward 86 Positive Health Program to implement RAPID.

Challenges: None noted.

Anticipated Changes:
PrIDE funding will be supplemented with PS18-1802 Component B funding for public health detailing and linkage staffing.

Activity 4.E. Promote and monitor HIV viral suppression

Successes:
We actively use HIV surveillance data to monitor HIV viral suppression including on the population level and by specific demographic groups. Viral suppression is monitored both among persons newly diagnosed with HIV and among persons living with HIV. This information is shared with HIV prevention partners for resource allocation and prioritization.

Challenges: None anticipated.

Anticipated Changes: None anticipated.

Activity 4.F. Monitor HIV drug resistance

Successes:

We routinely collect and process HIV nucleotide sequences reported by laboratories and use CDC processed HIV sequence dataset and accompanying SAS programs to assess transmitted drug resistance among new HIV diagnoses. We monitor the trend over time and results are presented in our HIV annual report for dissemination.

Challenges:
Stanford Clinical Virology laboratory which conducts HIV genotypic testing for SF Kaiser providers does not report to the Health Department. Approximately 17% of our new cases were diagnosed at SF Kaiser meaning that our genotyping data is incomplete for San Francisco.

Anticipated Changes:
We plan to work with the California State Office of AIDS and Association of Public Health Laboratories to assist Stanford laboratory with reporting via California's Reportable Disease Information Exchange (CalREDIE) system.

Activity 4.G. Conduct risk-reduction interventions for PLWH
- 4.6. Increased provision of risk reduction interventions for PLWH
- 4.7. Increased active referral to HIV prevention services for PLWH (Output)

Successes:
Risk reduction activities are not funded under PS18-1802, however all programs providing HIV testing including City Clinic and Jail Health Services have strong referral systems for client needs especially PEP, PrEP, STI services.

Challenges: None noted.

Anticipated Changes: None anticipated.

Activity 4.H. Actively refer PLWH to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services

- 4.9. Increased screening and active referral of PLWH to essential support services, including healthcare benefits, behavioral health services, and social services.

Successes:
18-1802 Funded and non-funded testing programs have referral systems in place with a focus on populations with the highest disparities in access to prevention, treatment and care.

SFDPH has worked with the San Francisco AIDS Foundation, the largest provider of community-based HIV testing who is also funded by 15-1502, to develop and adjust different models of referral to partner services, testing both active and passive referral mechanisms. All other agencies are required to report HIV positive clients to LINCS and the LINCS staff assess client need for referral.

Challenges: None noted.

Anticipated Changes: None anticipated.

1. Provide information on interventions and services for HIV-positive persons for the reporting period. **See Table in Appendix B.**

Strategy 5. Comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection

Activity 5.A. Provide periodic HIV testing and risk screening

Successes:
San Francisco continued high volume HIV testing at SFDPH City Clinic as well as in Jail Health Services with funding from 18-1802.

Using local funding, San Francisco continued high volume community-based testing for high prevalence populations (MSM, trans women, PWID) at San Francisco AIDS Foundation's Magnet clinic, UCSF Alliance Health Project, and as well as testing in agencies providing services to AAMSM (SFAF), Latino MSM (AGUILAS, IFR) trans women (SFCHC) and PWID (Glide, SFAF) and people in substance use treatment settings (Bayview Hunter's Point Foundation, Bay Area Addiction Research and Treatment (BAART), University of California Opiod Treatment Outpatient Program).

Challenges: None noted.

Anticipated Changes: None anticipated.

Activity 5.B. Provide screening for PrEP eligibility
- 5.2. Increased screening of HIV-negative persons for PrEP eligibility (Output)

Activity 5.C. Provide linkage to and support for PrEP
- 5.3. Increased active referral of persons eligible for PrEP to PrEP providers (Outcome)

Successes:

San Francisco continues to support its PrEP demonstration project as a service at its STD Clinic. San Francisco has continued to support a continuum of PrEP services at five community-based agencies providing services to AAMSM (SFAF), Latino MSM (AGUILAS, IFR) trans women (SFCHC) and PWID (Glide, SFAF.) and Youth (LYRIC).. Include PrEP as a component of all HIV test counselor trainings.

Challenges: None noted.

Anticipated Changes: None anticipated.

Activity 5.D. Provide risk reduction interventions for HIV-negative persons at risk for HIV infection

- 5.6. Increased provision of risk reduction interventions for HIV-negative persons at risk for HIV infection (Output)

Successes:
San Francisco continued its long standing support for Special Projects for prioritized populations, projects that include a full spectrum of services from outreach, engagement, testing, referral to PrEP or HIV/HCV/STI treatment as appropriate and medication maintenance for clients on PrEP or PLWH. This is a spectrum of prevention services, from low to high threshold at five agencies providing Special Project services to AAMSM, Latino MSM, trans women, and MSM.

Challenges: None noted.

Anticipated Changes:

Activity 5.E. Actively refer HIV-negative persons at risk for HIV infection to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services

- 5.8. Increased screening and active referral of HIV-negative persons at risk for HIV infection to essential support services, including healthcare benefits, behavioral health services, and social services.

Successes:
SFDPH continues to provide high volume HIV testing at SFDPH City Clinic, and high volume community- based testing for high prevalence populations (MSM, trans women, PWID) at San Francisco AIDS Foundation's Magnet clinic, UCSF Alliance Health Project, and as well as testing in agencies providing services through Special Projects for AAMSM (SFAF), Latino MSM (AGUILAS, IFR) trans women (SFCHC) and PWID (Glide, SFAF).

These testing programs have referral systems in place with a focus on populations with the highest

disparities in access to prevention, treatment and care.

Challenges: None noted.

Anticipated Changes: None anticipated.

1. Briefly describe which populations and what activities you supported for high-risk HIV-negative individuals during the reporting period?

   Priority populations in San Francisco are MSM with a focus on AAMSM and Latino MSM, PWUD, trans women and people experiencing homelessness.

2. Provide information on interventions and services for HIV-negative persons for the reporting period. **See Table in Appendix C**.

Strategy 6. Perinatal HIV prevention and surveillance activities
☒ Not applicable if opt-out approved

Strategy 7. Community-level HIV prevention activities
☒ Not applicable if opt-out approved

Activity 7.A. Conduct condom distribution programs
- 7.1. Increased availability of condoms among persons living with or at risk for HIV infection

Successes:
Partially Funded: Continue citywide condom distribution program (agencies/businesses can request free condoms from SFDPH). Distribute condoms and safer sex supplies at community venues such as bars and events and health fairs, such as Carnival, Pride, and Folsom Street Fair. Continue to provide condom distribution at SFDPH clinics and SFDPH- funded HIV prevention programs

Challenges: None noted.

Anticipated Changes: None anticipated.

Activity 7.B. Coordinate and collaborate with syringe services programs

Successes:
No syringe syringe services in San Francisco are supported by 18-1802.
SFDPH supports the San Francisco AIDS Foundation and its community-based subcontractors to provide syringe access and disposal programs throughout the City. The Syringe Access Collaborative of syringe providers, in partnership with SFDPH engage with communities and neighborhoods regarding importance of syringe services and in particular syringe disposal.

Expansion of disposal options include large kiosks and wall-mounted disposal boxes placed in "hot spots", outreach and focus groups to engage with community of users about syringe disposal; development of the SFDPH Community Health Response Team to address syringe disposal issues and piloting syringe access and disposal services at homeless encampments.

Challenges: None noted.

Anticipated Changes: None anticipated.

Activity 7.C. Conduct social marketing campaigns

Successes:
Not funded: Continued two existing campaigns funded by GTZ and PriDE funding that focus on reducing anti HIV stigma (U=U) and decreasing barriers to PrEP particularly among AAMSM and other communities of color (PrEP Supports).

Challenges: None noted.

Anticipated Changes:
Both social media campaigns will expand and use different placement strategies through 2018.

Activity 7.D. Implement social media strategies

Successes:
San Francisco has included social media strategies such as including ads for Social Marketing campaigns on gay "hook-up" apps such as Grnder, or more mainstream media channels such as FaceBook and YouTube as appropriate to the stated needs of constituents.

Challenges: None noted.

Anticipated Changes:
Both social media campaigns will expand and use different placement strategies through 2018.

Activity 7.E. Support community mobilization

Successes:
We have worked closely with the HCPC and other community partners to develop an integrated HIV/HCV/STD roadmap. A key emerging theme is the need to promote racial justice through our prevention and care efforts, which means developing innovative strategies for reaching and mobilizing communities of color. The upcoming RFP will provide an opportunity to increase our emphasis on mobilizing communities of color.

Challenges: None noted.

Anticipated Changes: None anticipated.

Indicate any CDC social marketing campaign that you promoted and/or supported during the reporting period?

No CDC social marketing campaign was implemented during the reporting period.

1.Provide the total number of condoms distributed overall during the reporting period.
491,592

2.Have you received concurrence from CDC for your submitted determination of need (DON) for Syringe Services Programs (SSP)? X Yes ☐ No

San Francisco is covered under a DON submitted by the State Office of AIDS on behalf of the entire state of California.

3.Describe SSP and harm reduction activities conducted during the reporting period for high-risk or vulnerable populations?

SFDPH Community Health Equity & Promotion (CHEP) Branch funds a collaborative of community-based organizations that provide client-centered harm reduction Syringe Access & Disposal services to people who inject drugs. There are 13 sites that operate throughout the City, providing coverage. Each site provides an opportunity for disposal. Each site offers harm reduction supplies, overdose prevention education, narcan trainings, and resources and referrals to HIV/Hep C testing, and other community services.

Strategy 8. Partnerships for integrated HIV prevention and care planning

Activity 8.A. Maintain HIV planning group

Successes:
San Francisco continues to maintain partnership with the HCPC and build Council members' capacity to participate in integrated planning. The councils are clearly merged. The HCPC as been critical in our planning for 18-1802. The HCPC is highly involved setting guiding principles and has also taken on the task of addressing both HIV Prevention and Care. In collaboration with SFDPH, the planning group writes, submits, disseminates and monitors an updated SF EMA Integrated HIV Prevention and Care Plan, which incorporates HCPC recommendations.

Challenges: None noted.

Anticipated Changes: None anticipated.

Activity 8.B. Develop HIV prevention and care networks

Successes:
SFDPH continues to have a productive working relationship with the HCPC and its subcommittees, including Membership, Community Engagement, Community Affairs and People Living with HIV. In addition, we continue to maintain and support GTZ initiatives and subcommittees using the goals and strategies of the initiative as a lens for prioritizing services, and during this reporting period we were able to hire a full-time GTZ Programs Coordinator to ensure that GTZ programs are coordinated with each other and with the larger system of care.

Challenges: None noted.

Anticipated Changes: None anticipated.

Did you make any changes to your Integrated HIV Prevention and Care Plan and/or planning group process during the reporting period?

Yes, we are in early stages of planning to further integrate Hep C elimination and STD reduction efforts into the plan that will be reflected in the RFP released 2019 and in future Plan updates.

Strategy 9. Implementation of structural strategies to support and facilitate HIV surveillance and prevention

Activity 9.A. Ensure data security, confidentiality, and sharing
- Outcome 9.1. Increased data security, confidentiality, and sharing

Successes:
SFDPH staff and funded contractors are trained in the local SFDPH data and confidentiality standards (which comply with NCHHSTP standards), the CDC security and confidentiality standards and the State Office of AIDS standards at the time of hire and yearly thereafter. SFDPH HIV surveillance maintains secure procedures for data sharing, including D2C activities and use of surveillance data across HIV programs including prevention programs and LINCS within the context of existing laws.

Challenges: None noted.

Anticipated Changes: None anticipated.

Activity 9.B. Strengthen laws, regulations, and policies

Successes:
The State of California has laws governing how HIV surveillance data is collected and shared in place that have allowed SFDPH HIV surveillance to successful ensure data security, confidentiality and sharing.

Challenges: None noted.

Anticipated Changes: None anticipated.

Activity 9.C. Strengthen health information systems infrastructure

Successes:
SFDPH is in the process of implementing a new electronic health record (EHR) system for DPH (Go Live is August 3, 2019). The two main hospitals (ZSFG and Laguna Honda Hospital), Ambulatory Care clinics, the Population Health Division clinics, the Public Health Laboratory, and Jail Health Services, and Behavioral Health clinics are undergoing adoption of the new EHR and we are currently in the adoption phase of the build. Representatives from HIV surveillance and HIV prevention have been meeting regularly with this EHR team to assess how the new EHR will enhance public health surveillance, analysis and reporting. We are identifying changes in work flows and resource needs that will support the new EHR when we are live with the new system while taking a critical look at improving our work flows and becoming more efficient in the work that we do. We are discussing metrics and reporting of standardized data definitions and processes.

Challenges: None noted.

Anticipated Changes:
When this system goes live, we will be able to automatic some of our current processes including for example, manual review of medical records for case updates.

Activity 9.D. Promote expansion of technological advances

Successes:
We started a pilot with a large community testing site to use DocuSign for passive case reporting. DocuSign improves the security and efficiency of data transmission and processing. The pilot will be used to identify reporting issues and inform protocol revisions and decisions for roll-out to other passive reporting sites.

Challenges: None anticipated.

Anticipated Changes:
We plan to expand the use of DocuSign for passive case reporting to other providers in 2019.

Security and Confidentiality
Notice: PS18-1802 recipients should comply with the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention's (NCHHSTP) Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011). All standards included in the NCHHSTP Data Security and Confidentiality Guidelines should be implemented for funding recipients funded by PS18-1802, unless otherwise justified. Security and Confidentiality successes, challenges, and anticipated changes for surveillance and prevention recipients should be described in the narrative. A "Certification of Compliance" (see example Certification of Compliance Statement, https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS18-1802-AttahchmentH-Offcial-Reponsible-Party-ORP-Certification-Sample-Template.pdf) must be signed by an overall responsible party or parties (ORP) and submitted annually to the PS18-1802@cdc.gov mailbox with a copy to the monitoring team at the same time the APR is submitted for the reporting period of 1/1/2018 – 6/30/2018 to www.GrantSolutions.gov.

For information on the data security and confidentiality guidelines and Sample Certification Statement, please refer to https://www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf .

Strategy 10. Data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities

Activity 10.A. Conduct data-driven planning for HIV surveillance, prevention, and care activities

- **10.1. Increased use of data to plan, monitor, evaluate, and improve HIV surveillance and prevention programs and monitor the impact of local HIV prevention efforts (Output)**

Successes:
This year SFDPH surveillance and prevention collaborated to produce the first Results Scorecard – for PrEP. It includes population-level indicators as well as program performance measures, so that all stakeholders can see the data in one place and assess whether our efforts are on track or need to shift. The scorecard is shared with CBO PrEP providers at their quarterly meeting, at which they review and interpret the data, share best practices, and identify areas for quality improvement. The next step is to share it with the GTZ PrEP Committee. Additional data analyses to inform HIV prevention and care activities are included in the HIV Epidemiology Annual Report and are widely disseminated to prevention partners both within and outside the SFDPH.

Challenges: None anticipated.

Anticipated Changes: None anticipated.

Activity 10.B. Conduct data-driven monitoring and evaluation and use findings to continuously improve HIV surveillance and prevention activities

Successes:
Program-level, strategy-level, and collective impact scorecards have begun to illuminate successes as well as disparities and gaps that need to be addressed. HIV surveillance data is being actively shared with GTZ subcommittees focusing on specific vulnerable populations including the homeless and people who inject drugs and with community prevention partners.

Challenges: None anticipated.

Anticipated Changes: None anticipated.

1. How are you using the most current epidemiologic and surveillance data for program planning, implementation, and evaluation purposes during the reporting period (i.e., data to care)? Include the types of data used.

   HIV surveillance data were used to identify persons living with HIV who are not linked to care and/or virally suppressed and shared with LINCS for assistance. Surveillance data were used to monitor potential HIV transmission clusters and identify persons in transmission clusters who are not virally suppressed for assistance through LINCS. Surveillance data were used to monitor trends among newly diagnosed and PLWH to inform prevention strategies including for example the focus of the 18-1802 Component B application and implementation.

2. How are you disseminating your program monitoring and evaluation data and providing feedback to your healthcare and non-healthcare providers and other community partners? How are you disseminating your surveillance data to inform prevention activities? Describe how HIV surveillance is receiving updated information (e.g., updated risk, residence, contact, or linkage status information) from program staff?

   Program monitoring and evaluation data is disseminated through multiple channels, including Program Liaison site visits with providers, prevention provider network meetings, the HCPC, and GTZ. We use these opportunities to share data and discuss what is working well and whether there are any gaps that need to be addressed. The primary tool for data sharing is the Results Scorecard.

HIV surveillance data is disseminated through semi-annual reports, the annual report and presentations to community and prevention partners including the SFDPH health commission, the GTZ consortium, the HPCP and community-based agencies. Updated surveillance information is collected through routine lab reporting of all CD4 and viral load test results, prospective chart review, other health departments, or data matches with other databases or disease registries.

Strategy 11. Capacity building activities for HIV programs, epidemiologic science, and geocoding

Activity 11.A. Assess capacity-building assistance needs
Activity 11.B. Develop and implement capacity- building assistance plans, including technical assistance

Successes:
As the new prevention strategies and activities are being developed, SFDPH will continue its communication with its community partners and HCPC and develop trainings to ensure providers are successful in their new ventures.

Challenge: None noted.

Anticipated changes:
2018 will be an intensive planning year for SFDPH as it embarks on formative work for an RFP being released in 2019. SFDPH will work closely with CBOs to plan for shifts in HIV prevention strategies and activities. CBA needs will be assessed and CBA plans developed annually thereafter.

Activity 11.C. Enhance epidemiologic and analytic capacity (e.g., data to care, cluster detection and investigation) and other prevention activities

Successes:
SFDPH has been conducting Data to Care activities as a joint activity between HIV surveillance and the LINCS program since 2012 and Data to Care activities have increased with CDC PrIDE funding in recent years. Drawing on past experience, we continue to refine and improve our Data to Care efforts and apply lessons learned in Data to Care to local Data to PrEP efforts. In addition, we will have implemented HIV-TRACE to identify recent and growing transmission clusters and are currently conducting a series of pilot tests to determine if HIV-TRACE is also an effective tool to identify persons of concern who are not virally suppressed.

Challenges: None anticipated.

Anticipated Changes: None anticipated.

Activity 11.D. Enhance geocoding and data linkage capacity

Successes:
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. In PS 18-1802 we will work with California State Office of AIDS under one Memorandum of Agreement for geocoding and data linkage to clean, standardize, and prepare geocoded data to submit to CDC. SFDPH does not anticipate any epidemiologic CBA need.

Challenges: None anticipated.

Anticipated Changes: None anticipated.

1. Did you access capacity building assistance (CBA)/technical assistance (TA) services during the reporting period? ☒ Yes ☐ No

   Note: CBA accessed and provided via CDC-funded providers will be pulled via CRIS. However, please explain (be specific) if any of the CBA/TA provided did not meet your needs/expectations.

   SFDPH's CBA/TA needs/expectations were met during this reporting period.

2. Please provide the type of CBA/TA received and the name(s) of CBA/TA provider(s) for any non-CDC provided CBA to include training provided by your internal training unit (if applicable).

   There are some CHEP staff members that provide training to both internal SFDPH employees as well as our local partners/community-based organizations (CBOs). Specifically, a California State Certified HIV Test Counselor Training is given by CHEP staff members to our funded providers five times a year which also modules on PrEP and HCV. These staff follow up and provide additional individual TA if requested to do so by a

provider/agency. Also, as needed several staff members provide training/TA in a variety of content-specific topics such as an HIV 101 course, syringe access and disposal, PrEP and HCV.

3. Please include CBA/TA needs for Year 2.

   SFDPH does not anticipate any CBA/TA needs at this time. If something arises that may require additional CBA/TA, SFDPH will access CRIS.

Note: Quantitative information for HIV testing and HIV Partner Services for Component A will be reviewed via the PS18-1802 Data Tables that will be auto-populated with NHM&E data submitted via EvaluationWeb®. Please review these tables (template) for reference.
Quantitative information for HIV surveillance, molecular HIV surveillance, perinatal HIV surveillance, and surveillance-based Data-to-Care will be captured in eHARS and reported in the end of calendar year Standards Evaluation Report (SER).

SECTION II: STAFFING AND MANAGEMENT

1. Please indicate any organizational and/or key staffing changes (i.e., health department staff responsible for implementing interventions and services for PS18-1802) that occurred during the reporting period. Please indicate any vacant staff positions and provide a detailed plan with timeline for hiring/filling vacancies. Were there any delays in executing contracts during the reporting period? If so, please explain and include any program implications?

   There are no current staffing vacancies and no key staffing changes in HIV Surveillance.

SECTION III: RESOURCES ALLOCATION (for HIV prevention funding only)

1. Please identify each city/MSA with at least 30% of the HIV burden within the jurisdiction. For directly-funded cities, please report areas (or zip codes) within the MSA with at least 30% of the HIV burden within the jurisdiction. If no area represents at least 30% of the HIV epidemic, then identify the top three MSA/MDs, cities, or areas within the jurisdiction that have the greatest burden of disease. **See Appendix D: Resource Allocation.**

SECTION IV: BUDGET

1. Did you submit a 424A form? See Budget Information and Justification under the instructions section.
2. Are you requesting new Direct Assistance (DA) in lieu of a portion of Financial Assistance (FA) for Year 2? If yes, please outline DA staffing needs. Recipients may request federal personnel, equipment, or supplies, including SAS licenses, as DA to support HIV surveillance and prevention activities. Recipients should include the requested number of SAS licenses in the APR budget. Recipient's FY2019 SAS license renewal process, MOA, and instructions will be released during the SAS campaign launch in September 2018. To address staffing and/or program expertise deficits, recipient may utilize DA to recruit staff with the requisite training, experience, expertise (e.g., Public Health Associate Program [PHAP]). For information on DA for assigning CDC staff to State, Tribal, Local, and Territorial Health agencies, refer to:
   https://www.cdc.gov/stltpublichealth/GrantsFunding/direct_assistance.html
3. Jurisdictions with eligible state and local (city or county) health departments must discuss: (1) the proposed program approach being implemented by the local health department and (2) how the state and local area will collaborate during the project period to ensure appropriate provision of services within the metropolitan area and document any agreements reached in a letter of agreement/letter of concurrence (LOA/LOC). Please submit current LOA with this submission. The current LOA will remain in place for the new budget period (Year 2: January 1, 2019 – December 31, 2019).
4. For resources and funding allocated in support of health information systems, please clearly indicate in the budget the specific system (i.e., eHARS) and amount. ~~Recipients should complete the eHARS Request Form for eHARS allocations.~~

Note: Please submit one line item budget for the core program that clearly delineates funding for HIV surveillance and HIV prevention within the budget narrative. Please provide one 424A that includes HIV surveillance on one column and HIV prevention on another column, and the total amount in the total column (one 424A with separate grant program functions). If funded under Component B demonstration project, please include a separate budget narrative and 424A form. A second option is to include all components on one 424A: Place Component A- Prevention in one column, Component A-Surveillance in another column, Component B in the third column, and the total (cumulative) in the column to the far right.

SECTION V: ASSURANCES OF COMPLIANCE

Instructions: Submit the completed forms for all materials used or proposed for use during the reporting period of **January 1, 2019 – December 31, 2019.** Attach the following Assurance of Compliance Forms to the application through the "Mandatory Documents" section of the "Submit Application Page" on Grants.gov. Select "Other Documents Form" and attach as a PDF file **(See Appendix E for template).**

- "Assurance of Compliance with the Program Guidance on the Review of HIV-Related Educational and Informational Materials for CDC Assistance Programs" (CDC 0.1113). Please see https://www.cdc.gov/hiv/pdf/funding/announcements/ps12-1201/cdc-hiv-ps12-1201-content-review-guidance.pdf to access the guidance document.

- "Assurances and Certifications: Download and complete all applicable Assurances and Certifications from http://wwwn.cdc.gov/grantassurances/Homepage.aspx. Upload these signed documents into the Assurances website identified in the instructions."

SECTION VI: CERTIFICATION OF NHM&E DATA SUBMISSION

1. As a part of the PS18-1802 Cooperative Agreement, in addition to the submission of the progress reports to CDC, recipients must also submit the required National HIV Monitoring and Evaluation (NHM&E) data variables, through the CDC-approved system (i.e., EvaluationWeb®) and commit them by the designated due date.

   Please certify below:

   ☒ We certify that the department of health has submitted/will submit all of the required NHM&E data (HIV Testing data, Partner Services data, as well as any other required aggregate data variables) to CDC via EvaluationWeb® and have committed/will commit them by the designated due date. And, that we have reviewed the EvaluationWeb® auto-populated PS18-1802 Data Tables.

2. Please include any additional comments and/or clarifications for your submitted NHM&E data and/or the PS18-1802 Data Tables. Please also include any justification(s) for partial/late data submission. Information provided will be used for consideration during the review process.

   ☒ No additional comments and/or clarifications needed.
   ☐ Additional comments and/or clarifications provided here:

Note: To better align the progress reporting and NHM&E data submission processes, as well as to reduce data burden, the quantitative NHM&E data entered into EvaluationWeb® will automatically populate the PS18-1802 Data Tables. This report will draw directly from required NHM&E data that you have submitted to CDC via EvaluationWeb®. As a follow-up to your data submission, please review the PS18-1802 auto-populated quantitative data tables (for Component A) within EvaluationWeb®. These quantitative reports will be used by project officers in addition to the qualitative progress report for the review and feedback process.

SECTION VII: ADDITIONAL INFORMATION

1. Additional Information

Please also provide any other explanatory information or data you think would be important for CDC to receive (e.g., additional coordination and collaborations to support PS18-1802, local processes or procedures impacting program implementation).

See cover letter.

APPENDICES

Appendix A: Partner Services

Provide information for newly diagnosed index patients for Partner Services in the table below.

Table 1. Newly Diagnosed, Confirmed HIV-positive Index Patients[1]

New HIV Cases Reported to HIV Surveillance Program[2]	Newly Diagnosed Index Patients Reported to Partner Services Program[3,4,5]	Newly Diagnosed Index Patients Eligible for Partner Services Interview[6]	Newly Diagnosed Index Patients Interviewed[7] n (%)		Partners Named[8]	Partners Named per Newly Diagnosed Index Patient Interviewed[9]
134	113	65	65	57	46	.71

[1] This table includes data for all partner services, regardless of funding source, not just those funded under PS18-1802.
[2] This is the number of new HIV case reports received by the health department surveillance program during the reporting period, based on date of report, rather than date of diagnosis.
[3] This is the number of newly diagnosed confirmed HIV-positive index patients reported to the health department partner services program during the reporting period, from any source.
[4] New diagnosis status verified, at minimum, by cross-check with the health department surveillance system. Supplementary methods of identifying previous diagnosis, such as review of laboratory reports, medical records, or other data sources (e.g., partner services database, evidence of previous treatment for HIV), or patient interview, may also have been used. If any data source, including patient self-report, indicates previous diagnosis, diagnosis is not new.
[5] Does not include index patients classified as newly diagnosed based only on 1) self-report of having had no previous test or having had a previous negative test or 2) review of other data sources (e.g., medical records, partner services database, treatment database).
[6] This is the number of newly diagnosed confirmed HIV-positive index patients reported to the health department partner services program during the reporting period (Column B), excluding those who are out of jurisdiction or deceased.
[7] This is the number of newly diagnosed confirmed HIV-positive index patients reported to the health department partner services program during the reporting period and eligible for partner services interview (Column C), who were interviewed for partner services by the health department or a person trained and authorized by the health department to conduct partner services interviews.
[8] This is the total number of partners named for whom the information provided by the index patient or otherwise available should be sufficient to allow the partner to be identified and notified by health department partner services workers.
[9] This is the average number of partners named by the newly diagnosed index patients who were interviewed.

Calculations:

E = (D/C) x 100

G = F/D

Appendix B: Interventions and Services for HIV-Positive Individuals

San Francisco does not fund interventions and services of the type listed below for HIV-positive individuals with 18-1802 funds.

Interventions and Services for HIV-Positive Individuals				
Target Population	Total # of HIV-Positive Persons Enrolled in Behavioral Risk Screening	Total # of HIV-Positive Persons Enrolled in Individual- and Group-level Evidence-based Interventions	Total # of HIV-Positive Persons Enrolled in Community-level Evidence-based Interventions	Total # of HIV-Positive Persons Enrolled in Other Locally Developed Programs

Appendix C: Interventions and Services for HIV-Negative Individuals

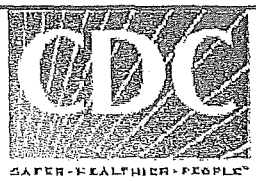
San Francisco does not fund interventions and services of the type listed below for high-risk HIV-negative individuals with 18-1802 funds.

Interventions and Services for High-Risk HIV-Negative Individuals				
Target Population	Total # of High-Risk HIV-Negative Persons Enrolled in Behavioral Risk Screening	Total # of High-Risk HIV-Negative Persons Enrolled in Individual- and Group-level Evidence-Based Interventions	Total # of High-Risk HIV-Negative Persons Enrolled in Community-level Evidence-Based Interventions	Total # of High-Risk HIV-Negative Persons Enrolled in Other Locally Developed Programs

Appendix D: Resource Allocation

Identify each city/MSA with at least 30% of the HIV burden within the jurisdiction. For directly-funded cities, please report areas (or zip codes) within the MSA with at least 30% of the HIV epidemic within the jurisdiction. If no area represents at least 30% of the HIV burden, then identify the top three MSA/MDs, cities, or areas within the jurisdiction that have the greatest burden of disease.

Reporting of MSAs/Cities/Areas with ≥ 30% of the HIV Epidemic within the Jurisdiction			
MSA/CITY/AREA	**Percentage of HIV Burden within the Jurisdiction**	**Percentage of PS18-1802 Funds Allocated**	**Strategies and Activities Funded**
San Francisco	100	100	San Francisco received a waiver for strategy 6, but otherwise all required strategies and activities are being implemented.



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with the

"PROGRAM GUIDANCE ON THE REVIEW OF HIV-RELATED EDUCATIONAL AND INFORMATIONAL MATERIALS FOR CDC ASSISTANCE PROGRAMS"

By signing and submitting this form, we agree to comply with the specifications set forth in the "Program Guidance on the Review of HIV-Related Educational and Informational Materials for CDC Assistance Programs," revised as of June 2016.

We agree that all written materials, audio visual materials, and pictorials, including social marketing and advertising materials, educational materials, social media communications (e.g., Facebook, twitter) and other electronic communications, such as internet/webpages will be submitted to a Program Review Panel. The Panel shall be composed of no less than five persons representing a reasonable cross-section of the general population; but which is not drawn predominantly from the intended audience. See additional requirements in the referenced program guidance, especially section 2 (c-d) (1-5) regarding composition of Panel.

The Program Review Panel, guided by the CDC Basic Principles, set forth in 1(a-g), will review and approve all applicable materials before their distribution and use in any activities funded in any part with CDC assistance funds.

Following are the names, occupations, and organizational affiliations of the proposed panel members: (If panel has more members than can be shown here, please indicate additional members on the reverse side.)

CDC 0.1113 (E), Rev. 6/2016, CDC Adobe Acrobat DC Electronic Version, 6/2016

NAME	OCCUPATION	AFFILIATION
Dale Gluth	Evaluation/QI Specialist	Office of Equity and Quality Improvement
Celia Gomez	Substance Use Specialist	Community Member
David Gonzalez	Unemployed	Community Member
Travis Tuohey	Assistant Director	CBHS LEGACY Program
Oscar Macias	Health Program Coordinator I	Community Health Equity & Promotion Branch (Health Department Representative)

Applicant/Recipient Name: San Francisco Department of Public Health	**Grant Number (If Known):** 93.940 (CFDA) PS18-1802
Signature: Project Director Tracey Packer	**Signature: Authorized Business Official** Christine Siador

Upload #6

Applicant:	San Francisco Department of Public Health
Application Number:	NU62PS2018003083
Project Title:	San Francisco Dept of Public Health High Impact Prevention
Status:	Submitted
Document Title:	Combined Jurisdictional EPMP

PS18-1802 Combined Jurisdictional Evaluation Performance Measurement Plan (EPMP) and Work Plan for Component A

(Updated May 1, 2018)

Name of Jurisdiction/Agency Submitting Plan: San Francisco

Point of Contact for Correspondences: Tracey Packer
Mailing Address: Suite 500, 25 Van Ness Avenue, SF, CA 94102
Email: tracey.packer@sfdph.org
Phone:415.437.6223
Fax:.

Version/Document Date: August 31, 2018.

Table of Contents

I. Program Description

Section 1: Brief Description of the PS18-1802 Project Being Implemented (Abstract)

In approximately 800 words, please provide a brief, high-level narrative summary of your PS18-1802-funded program as it will be implemented over the course of the five-year project period.

In 2013 SF launched the "Getting to Zero SF" initiative 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. Nevertheless, HIV surveillance data show that significant disparities in linkage, retention, and viral suppression among people living with HIV remain. African-Americans and Latinos, trans and cis-gender women, people who inject drugs, and people experiencing homelessness are less likely to be virally suppressed. In terms of new diagnoses, people of color make up an increasingly higher percentage of new diagnoses. SFDPH's Component A proposal expands on the Department of Public Health's (SFDPH's) commitment to fully integrate surveillance and prevention programs. It supports and maintains 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 focus on vulnerable and emerging populations at risk for HIV.

2018 is a planning year for SFDPH and much energy is being focused on examining current epi data and examining the strengths and challenges of current programs and means of operating. We expect to be releasing an RFP in the early part of the 2019 that will respond to changes in approaches, populations and resource allocation; when

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Section 2: PS18-1802 Program Logic Model

1. Below is the CDC logic model for PS18-1802, including all required HIV Prevention goals/priorities (e.g., increase individual knowledge of HIV status), strategies (e.g., identify persons with HIV infection and uninfected persons at risk for HIV infection), primary activities (e.g., conduct HIV testing), and outputs/outcomes (e.g., increased number of persons living with HIV infection who are aware of their HIV status). To meet the requirements of PS18-1802, unless otherwise exempted, your program must address all the goals/priorities, strategies, primary activities, outputs and outcomes noted in the logic model; however, you are only required to submit data to CDC for the outputs/outcomes bolded in blue. You may adopt this logic model for your local PS18-1802 program without modification; however, if you wish to include more detail in your logic model, you may add CDC-required sub-activities (e.g., implement and/or coordinate opt-out HIV testing of patients in healthcare settings; implement and/or coordinate targeted HIV testing in non-healthcare settings), locally defined sub-activities, or locally defined outputs/outcomes.

Logic Model – PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments
Part 1: Core Strategies & Activities

Strategies & Activities	Short-term Intended Outputs and Outcomes	Intermediate Intended Outcomes
HIV Prevention Goal/Priority 1: Cross-cutting surveillance core strategy		
Strategy 1	Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response	
Activity 1.A. HIV surveillance • Collect HIV case data, including (but not limited to) data on CD4 cell count, HIV viral load, molecular laboratory test results, vital status, and geocoding	• 1.1. Improved completeness, timeliness, and quality of HIV surveillance data (Outcome) • 1.2. Improved monitoring of trends in HIV infection (Outcome) • 1.3. Increased use of surveillance and epidemiological data to guide prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services (Output)	
	• 1.4. Increased use of geocoded data linked to census and social determinants of health datasets to guide prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services (Output)	
	• 1.5. Increased ability to describe the geographic distribution of HIV and understand the social determinants of health in relation to HIV and HIV-related health disparities (Outcome)	
Activity 1.B. HIV prevention program monitoring & evaluation • Collect data to monitor and evaluate HIV prevention programs	• 1.6. Improved completeness, timeliness, and quality of HIV prevention program data (Outcome)	
HIV Prevention Goal/Priority 2: Increase individual knowledge of HIV status		
Strategy 2	Identify persons with HIV infection and uninfected persons at risk for HIV infection	
Activity 2.A. Conduct HIV testing	• 2.1. Increased HIV testing among persons at risk for HIV infection (Output) • 2.2. Increased number of persons living with HIV infection who are aware of their HIV status (Outcome) • 2.3. Increased identification of HIV-negative persons at risk for HIV infection (Output)	
Activity 2.B. Conduct HIV partner services	• 2.4. Increased participation in HIV partner services among persons with diagnosed HIV infection, identified through PS18-1802-funded testing (Outcome) • 2.5. Increased participation in HIV partner services among persons with diagnosed HIV infection, identified throughout the jurisdiction (Outcome)	

Logic Model – PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments Part 1: Core Strategies & Activities			
Strategies & Activities		Short-term Intended Outputs and Outcomes	Intermediate Intended Outcomes
		• 2.6. Increased partner elicitation through HIV partner services interviews of index patients with newly diagnosed HIV infection (Outcome) • 2.7. Increased notification and HIV testing of partners identified through HIV partner services (Output) • 2.8. Increased number of partners living with HIV infection who are aware of their HIV status (Outcome)	
		• 2.9. Improved laboratory reporting to HIV surveillance (Output)	
HIV Prevention Goal/Priority 3: Rapidly detect and interrupt HIV transmission			
Strategy 3	Develop, maintain, and implement a plan to respond to HIV transmission clusters and outbreaks		
Activity 3.A. Identify and investigate HIV transmission clusters and outbreaks		• 3.1. Improved early identification and investigation of HIV transmission clusters and outbreaks (Outcome)	
Activity 3.B. Rapidly respond to and intervene in HIV transmission clusters and outbreaks		• 3.2. Improved response to HIV transmission clusters and outbreaks (Outcome)	
Activity 3.C. Maintain outbreak identification and response plan		• 3.3. Improved plan and policies to respond to and contain HIV outbreaks (Outcome)	
HIV Prevention Goal/Priority 4: Reduce transmission from persons living with HIV infection			
Strategy 4	Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH)		
Activity 4.A. Provide linkage to HIV medical care for persons with newly and previously diagnosed HIV infection identified through HIV testing and partner services		• 4.1. Increased linkage to and retention in HIV medical care among PLWH (Outcome)	• 4.5. Increased HIV viral load suppression among PLWH (Outcome)

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Logic Model – PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments Part 1: Core Strategies & Activities		
Strategies & Activities	**Short-term Intended Outputs and Outcomes**	**Intermediate Intended Outcomes**
Activity 4.B. Conduct data-to-care activities ▪ Identify persons with previously diagnosed HIV infection who are not in care through data-to-care activities ▪ Provide linkage to, re-engagement in, and retention in HIV medical care services for persons with previously diagnosed HIV infection who are not in care identified through data-to-care activities	• 4.2. Increased use of surveillance data to support PLWH throughout the HIV care continuum (Output)	
Activity 4.C. Promote early ART initiation	• 4.3. Increased early initiation of ART among PLWH (Outcome)	
Activity 4.D. Support medication adherence	▪ 4.4. Increased provision of ART medication adherence support for PLWH (Output)	
Activity 4.E. Promote and monitor HIV viral suppression		
Activity 4.F. Monitor HIV drug resistance	Click enter outputs/outcomes.	
Activity 4.G. Conduct risk-reduction interventions for PLWH	• 4.6. Increased provision of risk reduction interventions for PLWH (Output) • 4.7. Increased active referral to HIV prevention services for PLWH (Output)	• 4.8. Decreased risk behaviors among PLWH at risk of transmission (Outcome)
Activity 4.H. Actively refer PLWH to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services	• 4.9. Increased screening and active referral of PLWH to essential support services, including healthcare benefits, behavioral health services, and social services (Output)	
HIV Prevention Goal/Priority 5: Prevent new infections among HIV-negative persons		
Strategy 5	**Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection**	
Activity 5.A. Provide periodic HIV testing and risk screening	• 5.1. Increased periodic HIV testing and risk screening among persons at risk for HIV infection (Output)	

Logic Model – PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments Part 1: Core Strategies & Activities		
Strategies & Activities	**Short-term Intended Outputs and Outcomes**	**Intermediate Intended Outcomes**
Activity 5.B. Provide screening for PrEP eligibility	• 5.2. Increased screening of HIV-negative persons for PrEP eligibility (Output)	
Activity 5.C. Provide linkage to and support for PrEP	• 5.3. Increased active referral of persons eligible for PrEP to PrEP providers (Outcome)	• 5.4. Increased linkage of persons eligible for PrEP to PrEP providers (Outcome) • 5.5. Increased prescription of PrEP to persons for whom PrEP is indicated (Outcome)
Activity 5.D. Provide risk reduction interventions for HIV-negative persons at risk for HIV infection	• 5.6. Increased provision of risk reduction interventions for HIV-negative persons at risk for HIV infection (Output)	• 5.7. Decreased risk behaviors among HIV-negative persons at risk for HIV and other STDs (Outcome)
Activity 5.E. Actively refer HIV-negative persons at risk for HIV infection to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services	• 5.8. Increased screening and active referral of HIV-negative persons at risk for HIV infection to essential support services, including healthcare benefits, behavioral health services, and social services (Output)	
Strategy 6	**Conduct perinatal HIV prevention and surveillance activities**	
Activity 6.A. Promote universal prenatal HIV testing	• 6.1. Increased HIV screening among pregnant women (Output) • 6.2. Increased number of pregnant women who are aware of their HIV status (Outcome)	• 6.8. Reduced perinatally acquired HIV infection (Outcome)
Activity 6.B. Provide perinatal HIV service coordination	• 6.3. Increased provision of perinatal HIV services or service coordination among pregnant women living with diagnosed HIV and their infants (Output)	
	• 6.4. Improved provision or coordination of perinatal HIV services (Outcome)	
Activity 6.C. Conduct case surveillance for women with diagnosed HIV infection and their infants	• 6.5. Increased completeness, timeliness, and quality of HIV surveillance data for pediatric cases and HIV-exposed infant (Outcome)	
Activity 6.D. Conduct perinatal HIV exposure reporting	• 6.6. Increased use of surveillance and epidemiological data to guide perinatal prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services (Output)	

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Logic Model – PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments Part 1: Core Strategies & Activities		
Strategies & Activities	**Short-term Intended Outputs and Outcomes**	**Intermediate Intended Outcomes**
Activity 6.E. Conduct fetal and infant mortality reviews	• 6.7. Increased review of cases demonstrating missed prevention opportunities (Output)	
HIV Prevention Goal/Priority 6: Cross-cutting program core strategy		
Strategy 7	**Conduct community-level HIV prevention activities**	
Activity 7.A. Conduct condom distribution programs	• 7.1. Increased availability of condoms among persons living with or at risk for HIV infection (Outcome)	
Activity 7.B. Coordinate and collaborate with syringe services programs		• 7.2. Increased access to syringe services programs for persons who inject drugs (Outcome)
Activity 7.C. Conduct social marketing campaigns		• 7.3. Increased awareness among members of affected communities regarding potential risk for transmitting or acquiring HIV infection and knowledge of strategies for reducing these risks (Outcome)
Activity 7.D. Implement social media strategies		• 7.4. Reduced stigma and discrimination for persons diagnosed with HIV infection (Outcome)
Activity 7.E. Support community mobilization		
HIV Prevention Goal/Priority 7 (Cross-cutting): Reduce HIV-related health inequities		

Logic Model – PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments
Part 2: Operational and Foundational Strategies & Activities

Strategies & Activities	Short-term Intended Outputs and Outcomes	Intermediate Intended Outcomes
HIV Prevention Goal/Priority 8: Cross-cutting operational and foundational strategies		
Strategy 8	**Develop partnerships to conduct integrated HIV prevention and care planning**	
Activity 8.A. Maintain HIV planning group		• 8.1. Increased coordination of, availability of, and access to comprehensive HIV prevention, treatment, and support services (Outcome)
Activity 8.B. Develop HIV prevention and care networks		
Strategy 9	**Implement structural strategies to support and facilitate HIV surveillance and prevention**	
Activity 9.A. Ensure data security, confidentiality, and sharing	• Outcome 9.1. Increased data security, confidentiality, and sharing	
Activity 9.B. Strengthen laws, regulations, and policies		• 9.2. Reduced systemic, legal, regulatory, organizational, operational, social, or cultural barriers to HIV surveillance, prevention, and care (Outcome)
Activity 9.C. Strengthen health information systems infrastructure		
Activity 9.D. Promote expansion of technological advances		
Strategy 10	**Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities**	
Activity 10.A. Conduct data-driven planning for HIV surveillance, prevention, and care activities	• 10.1. Increased use of data to plan, monitor, evaluate, and improve HIV surveillance and prevention programs and monitor the impact of local HIV prevention efforts (Output)	• 10.2. Increased coordination and integration of comprehensive HIV prevention and care services (Outcome) • 10.3. Improved targeting of HIV testing, prevention, and care resources, funding, and services (Outcome)

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Logic Model – PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments Part 2: Operational and Foundational Strategies & Activities		
Strategies & Activities	**Short-term Intended Outputs and Outcomes**	**Intermediate Intended Outcomes**
Activity 10.B. Conduct data-driven monitoring and evaluation and use findings to continuously improve HIV surveillance and prevention activities		• 10.4. Improved targeting, prioritization, and effectiveness of funded HIV prevention activities (Outcome) • 10.5. Improved targeting of HIV programs to address HIV-related health disparities (Outcome)
Strategy 11	**Build capacity for conducting effective HIV program activities, epidemiologic science, and geocoding**	
Activity 11.A. Assess capacity-building assistance needs	• 11.1. Increased capacity-building support, including technical assistance, within the jurisdiction (including CBOs and other partners) (Output) • 11.2. Increased jurisdictional capacity to conduct HIV surveillance and prevention activities (including data-to-care activities) (Output)	
Activity 11.B. Develop and implement capacity-building assistance plans, including technical assistance		
Activity 11.C. Enhance epidemiologic and analytic capacity (e.g., data to care, cluster detection and investigation) and other prevention activities		• 11.3. Strengthened interventional surveillance and response capacity (Outcome)
Activity 11.D. Enhance geocoding and data linkage capacity	• 11.4. Enhanced capacity to geocode, manage, link, and integrate surveillance and other data for surveillance, prevention, and care (Output)	• 11.5. Enhanced knowledge of the influence of social determinants on risk for disease and continuum of care outcomes (Outcome)

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2. In Table 1. below, please list any required primary activities or sub-activities from which your program has been exempted. Johnny done

Table 1. Approved Surveillance and Prevention Activity Exemptions

Activity or Sub-activity	Exemption Period	Based on	Project Officer Approved by	Date Approved
Perinatal Surveillance HIV Exposure Reporting (PHER)	Life of grant.	0 perinatal HIV diagnoses in the jurisdiction in 12 years.	Carla Alexander-Pender & Benjamin Laffoon	10/18/17 & 10/19/17

FIMR HIV methodology	Life of grant.	0 perinatal HIV diagnoses in the jurisdiction in 12 years.	Carla Alexander-Pender & Benjamin Laffoon	10/18/17 & 10/19/17

Section 3: Priority/Target Populations and Health Disparities

In Table 2 below, please describe, 1) 3-5 populations you will prioritize or target to receive HIV prevention services under your PS18-1802 program, 2) the needs identified for each population listed, and 3) the program strategies and activities planned to address the identified needs. The priority populations described in Table 2 should be congruent with those identified in your integrated care and prevention plan. If there are populations that you plan to prioritize or target for HIV prevention services, but will provide those services with funding other than that received under PS18-1802, please include them in the table and indicate "other" funding source.

Table 2. Priority/Target Populations

Priority/Target Populations	Identified Needs	Primary Strategies & Activities to Address Needs	Funding Source	
			PS18-1802	Other
Living with HIV but unaware	Condom distribution Health education Pre-exposure prophylaxis (PrEP) Non-occupational exposure prophylaxis (nPEP) HIV testing STD testing Partner services	Strategy 2: Identify persons with HIV infection and uninfected persons at risk for HIV infection 2.1. Increased HIV testing among persons at risk for HIV infection 2.4. Increased participation in HIV partner services among persons with diagnosed HIV infection, identified through PS18-1802-funded testing 2.5. Increased participation in HIV partner services among persons with diagnosed HIV infection, identified throughout the jurisdiction 2.6. Increased partner elicitation through HIV partner services interviews of index patients with newly diagnosed HIV infection 2.7. Increased notification and HIV testing of partners identified through HIV partner services Strategy 7 Conduct community-level HIV prevention activities 7.1. Increased availability of condoms among persons living with or at risk for HIV infection	Partially funded	CCSF General Fund.

		Goal 7: Reduce HIV-related health inequities		
PrEP-eligible but not on PrEP	Condom distribution Health education Non-occupational exposure prophylaxis (nPEP) HIV testing STD testing Partner services	Strategies 2 and 7 and Goal 7 as described above and: Strategy 5 Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection 5.2. Increased screening of HIV-negative persons for PrEP eligibility 5.3. Increased active referral of persons eligible for PrEP to PrEP providers	Partially funded	CCSF General Fund.
Men who have sex with men	Condom distribution; Health education Pre-exposure prophylaxis (PrEP) Non-occupational exposure prophylaxis (nPEP) HIV testing STD testing Partner services	Strategies 2, 5 and 7, & Goal 7 as described above and: Strategy 4 Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection 4.1. Increased linkage to and retention in HIV medical care among PLWH 4.4. Increased provision of ART medication adherence support for PLWH	Partially funded	CCSF General Fund.
People who inject drugs	Condom distribution; Health education Pre-exposure prophylaxis (PrEP) Non-occupational exposure prophylaxis (nPEP) HIV testing STD testing Partner services Syringe access services.	Goal 7 and activities for Strategies 2 ,4, 5 and 7 as described above and support local syringe access services.	Partially funded	CCSF General Fund.
Trans women	Condom distribution; Health education Pre-exposure prophylaxis (PrEP) Non-occupational exposure prophylaxis (nPEP) HIV testing STD testing Partner services	Strategies 2, 4, 5 and 7, & Goal 7 as described above.	Partially funded	CCSF General Fund.

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In the tables below, please describe, concisely, what will be done in Year 1 and Years 2-5 under each CDC-required primary HIV prevention activity (e.g., conduct HIV testing), surveillance activity (e.g., collect HIV case data), CDC-required sub-activity (e.g., implement and/or coordinate opt-out HIV testing of patients in healthcare settings; CIDR, risk factor ascertainment, data quality), and locally defined that will be implemented to address the PS18-1802 goals/priorities and strategies. Add lines as needed.

Note: The primary activities and sub-activities should be the same as those identified in your PS18-1802 program logic model (Section 2).

Goal/Priority 1: Cross-cutting Core Surveillance and Program Monitoring & Evaluation Activities		
Activities & Sub-activities	What will be done	
	Year 1	Years 2-5
Strategy 1: Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response		
Activity 1.A: HIV surveillance: Collect HIV case data, including (but not limited to) data on CD4 cell count, HIV viral load, molecular laboratory test results, vital status, and geocoding	SFDPH will conduct ongoing HIV case 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. Data collected will be continually evaluated for completeness, timeliness and accuracy. The data will be shared with clinical and community-based providers and San Francisco's integrated HIV prevention and care planning group, the HIV Community Planning Council (HCPC) HIV prevention strategies will be rapidly adjusted to align with the most current trends.	No anticipated changes.
Activity 1.B: HIV prevention program monitoring & evaluation: Collect data to monitor and evaluate HIV prevention programs	EvaluationWeb will be used as the repository of and reporting system for HIV testing data for both 18-1802 funded and non-18-1802 funded programs. In some cases, data is keyed in but all other 18-1802 data is uploaded from agencies' own systems.	EvaluationWeb variables will change as of 01/01/2019; San Francisco has been working with Luther Consulting and developing internal strategies to implement these changes and pass this off to our providers.

Goal/Priority 2: Increase individual knowledge of HIV status		
Activities & Sub-activities	What will be done	
	Year 1	Years 2-5
Strategy 2: Identify persons with HIV infection and uninfected persons at risk for HIV infection		
Activity 2.A: Conduct HIV testing	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	SFDPH is currently conducting a "Roadmap" process that will inform a change in strategies and approaches to HIV prevention and care activities. The resulting changes in systems and program requirements will be described in an RFP expected to be released in early 2019, for services beginning in July or September. We will continue to provide

	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 6% of PLWH who are unaware of their infection. Although not supported by 18-1802, San Francisco will continue to report on testing performed in medical settings.	updates to our Project Officers on this process and our discussions during our regular scheduled teleconferences.
Activity 2.B: Conduct HIV partner services (for new and previously diagnosed persons).	Partner services will be offered to all clients newly diagnosed with HIV. Partner services will also be offered to not-in-care clients enrolled in navigation who are IDU, women, diagnosed with an STD or identified to be part of a transmission cluster.	No anticipated changes.

Goal/Priority 3:	**Rapidly detect and interrupt HIV transmission**	
Strategy 3: Develop, maintain, and implement a plan to respond to HIV transmission clusters and outbreaks		
Activities & Sub-activities	**What will be done**	
	Year 1	**Years 2-5**
Activity 3.A: Identify and investigate HIV transmission clusters and outbreaks	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). 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.	No anticipated changes.
Activity 3.B: Rapidly respond to and intervene in HIV transmission clusters and outbreaks	SFDPH will prioritize and investigate transmission clusters that are concerning for recent and ongoing transmission. For newly identified HIV- positive cluster members, prioritize for rapid intervention and partner services. PLWH in transmission clusters who are not virally suppressed will be prioritized for engagement in HIV care services.	No anticipated changes, but will consistently monitor for any changes in demographics or other trends.
Activity 3.C: Maintain outbreak identification and response plan	SFDPH has an extensive infectious disease emergency response plan involving multiple branches within the SFDPH Population Health Division. We will modify this plan to specifically address a potential HIV outbreak or rapidly	No anticipated changes.

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	growing transmission cluster. As part of the response, we will confirm the cluster, identify and characterize risk networks involved with the cluster, and identify communities who are in need of targeted testing, prevention efforts, and linkage to care. SFDPH staff regularly discuss all-hazards response plans with other jurisdictions throughout the San Francisco Bay Area and the state. We will utilize existing health alert communication systems in order to communicate with other public health professionals as needed. As part of our ongoing public health emergency preparedness and response plans, we are assessing and evaluating jurisdictional capacity for cluster detection and response involving epidemiological investigations and surveillance on an ongoing basis.	

Goal/Priority 4: Reduce transmission from persons living with HIV infection		
Strategy 4: Provide comprehensive HIV-related prevention services for people living with diagnosed HIV infection		
Activities & Sub-activities	**What will be done**	
	Year 1	Years 2-5
Activity 4.A: Provide linkage to HIV medical care for persons with newly and previously diagnosed HIV infection identified through HIV testing and partner services	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.	No anticipated changes. We plan to work to work with San Francisco Health Network and Ryan White case managers to improve retention of PLWH who are loosely engaged in care.
Activity 4.B: Conduct data-to-care (DTC) activities. Identify persons with previously diagnosed HIV infection who are not in care (NIC) through data-to-care activities. Provide linkage to, re-engagement in, and retention in HIV medical care services for persons with previously diagnosed HIV infection who are not in care identified through data-to-care activities.	HIV surveillance will continue to support the LINCS team in DTC activities by providing lists of PLWH who are not virally suppressed or linked to HIV care, those with early infection or other prioritized groups. In addition, HIV surveillance will match clinic generated NIC lists to eHARS to identify persons to prioritize for investigation and navigation. Persons identified in transmission clusters who are not linked to care or virally suppressed will also be included in NIC lists provided to LINCS.	No anticipated changes.

Activity 4.C: Promote early ART initiation	Rapid initiation of treatment for those testing HIV positive is a pillar of San Francisco's Getting to Zero efforts and is a priority for all linkage to care efforts. Through component B funding, SFDPH has implemented public health detailing to educate medical providers and frontline workers about RAPID as well as LINCS and PrEP.	No anticipated changes.
Activity 4.D: Support medication adherence	Programs funded to serve HIV positive clients have two primary goals, to link to care and to maintain HIV treatment in order to reduce HIV viral load to undetectable and agencies must report on their efforts. Through component B funding, SFDPH is exploring opportunities to improve medication safe storage, particularly for patients who are homeless or unstably housed. For programs providing PrEP, navigation services are available to ensure maintenance out to six months of initiation.	No anticipated changes.
Activity 4.E: Promote and monitor HIV viral suppression	Viral suppression at the population level is monitoring by analyses of HIV surveillance data for persons newly diagnosed with HIV as well as viral suppression among all PLWH. SFDPH is working with quality improvement efforts and EMR team in the San Francisco Health Networks to routinely identify PLWH who are presenting for services but are not engaged in primary care.	The San Francisco Health Network will migrate to EPIC EMR in Fall 2019. We will assist in the development of new workflow to ensure routine HIV panel management and improved understanding of care coordination team in the EMR record.
Activity 4.F: Monitor HIV drug resistance	SFDPH collects, process, and import HIV nucleotide sequences to eHARS routinely. We monitor transmitted drug resistance over time using CDC processed HIV sequence dataset and accompanying SAS programs. The results are presented in SFDPH HIV annual report for dissemination.	No changes. We will work with State Office of AIDS and Association of Public Health Laboratories to assist Stanford Laboratory with reporting to improve the completeness of HIV nucleotide sequence data.

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Activity 4.G: Conduct risk-reduction interventions for PLWH	All SFDPH programs serving prioritized populations have goals of linking to appropriate HIV/HCV/STI testing and treatment as well as referral to PEP and PrEP. These services have been integrated into holistic programs or "Special Projects" to meet the needs of prioritized populations, i.e. MSM and AAMSM (SFAF), Latino MSM (AGUILAS & IFR) and trans women (SFCHC). All activities within these Special Projects for PLWH have the objective of linkage to care, retention in treatment and medication adherence.	No anticipated changes.
Activity 4.H: Actively refer PLWH to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services	18-1802 Funded and non-funded testing programs have referral systems in place with a focus on populations with the highest disparities in access to prevention, treatment and care.	No anticipated changes.

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Goal/Priority 5: Prevent new infections among HIV negative persons		
Strategy 5: Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection		
Activities & Sub-activities	**What will be done**	
	Year 1	**Years 2-5**
Activity 5.A: Provide periodic HIV testing and risk screening	Continue high volume HIV/STI testing at SFDPH City Clinic. This activity is funded by 18-1802. Continue HIV/STI/HCV testing in Jail Health Services which is partially funded by 18-1802. Continue high volume community- based HIV/HCV/STI testing for high prevalence populations (MSM, trans women, PWID) at San Francisco AIDS Foundation's Magnet clinic, UCSF Alliance Health Project, and as well as testing in agencies providing services to AAMSM (SFAF), Latino MSM (AGUILAS, IFR) trans women (SFCHC) and PWID (Glide, SFAF) in "Special Projects. Continue HIV/HCV testing in substance use treatment settings (Westside, Bayview Hunter's Point Foundation,	No anticipated changes
Activity 5.B: Provide screening for PrEP eligibility	Continue continuum of PrEP services in community-based settings at five agencies providing services to MSM (AHP) AAMSM (SFAF), Latino MSM (AGUILAS, IFR) trans women	No anticipated changes

	(SFCHC) and Youth (LYRIC). Continue continuum of PrEP services in clinical settings at San Francisco City Clinic, SFDPH Primary Care clinics and Mission Wellness Pharmacy.	
Activity 5.C: Provide linkage to and support for PrEP	Provide services as in 5B above and include PrEP as a component of all HIV test counselor trainings.	No anticipated changes
Activity 5.D: Provide risk reduction interventions for HIV-negative persons at risk for HIV infection	Continue spectrum of prevention services, from low to high threshold at five agencies providing services to AAMSM, Latino MSM, trans women, and MSM through Special Projects as described above.	No anticipated changes
Activity 5.E: Actively refer HIV-negative persons at risk for HIV infection to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services	Funded: Continue high volume HIV testing at SFDPH City Clinic. Non-funded: Continue high volume community- based testing for high prevalence populations (MSM, trans women, PWID) at San Francisco AIDS Foundation's Magnet clinic, UCSF Alliance Health Project, and as well as testing in agencies providing services to AAMSM (SFAF), Latino MSM (AGUILAS, IFR) trans women (SFCHC) and PWID (Glide, SFAF). These testing programs have referral systems in place with a focus on populations with the highest disparities in access to prevention, treatment and care.	No anticipated changes
Strategy 6: *Conduct perinatal HIV prevention and surveillance activities (or indicate if opt-out has been approved by CDC)*		
Activity 6.A: Promote universal prenatal HIV testing	*San Francisco was granted a waiver for Strategy 6 given 12 years of 0 perinatal transmissions.*	
Activity 6.B: Provide perinatal HIV service coordination		
Activity 6.C: Conduct case surveillance for women with diagnosed HIV infection and their infants		

Goal/Priority 5:	***Prevent new infections among HIV negative persons***	
Activity 6.D: Conduct perinatal HIV exposure reporting		
Activity 6.E: Conduct fetal and infant mortality reviews		

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Goal/Priority 6: Cross-cutting Program Core Strategy		
Strategy 7: Conduct community-level HIV prevention activities (or indicate if opt-out has been approved by CDC)		
Activities & Sub-activities	What will be done	
	Year 1	Years 2-5
Activity 7.A: Conduct condom distribution programs	Continue citywide condom distribution program (agencies/businesses can request free condoms from SFDPH). Distribute condoms and safer sex supplies at community venues such as bars and events and health fairs, such as Carnival, Pride, and Folsom Street Fair. Continue to provide condom distribution at SFDPH clinics and SFDPH- funded HIV prevention programs	No anticipated changes.
Activity 7.B: Coordinate and collaborate with syringe services programs	Not funded: Continue to support San Francisco AIDS Foundation and its community-based subcontractors to provide syringe access and disposal programs throughout SF. Continue to expand disposal options, including large kiosks and wall-mounted disposal boxes placed in "hot spots". Continue to outreach and convene focus groups to engage with community of users about syringe disposal. Continue to engage with communities and neighborhoods regarding importance of syringe services. Continue to develop DPH Community Health Response Team to address syringe disposal issues. Continue to pilot syringe access and disposal services at homeless encampments.	No anticipated changes.
Activity 7.C: Conduct social marketing Campaigns	Continue two existing campaigns funded by GTZ and PriDE that focus on reducing anti HIV stigma and decreasing barriers to PrEP particularly among AAMSM and other communities of color.	No anticipated changes.
Activity 7.D: Implement social media strategies	Ensure that current and upcoming social marketing campaigns continue to incorporate social media strategies in	No anticipated changes.

	their efforts when appropriate for the audience.	
Activity 7.E: Support community mobilization	Work with the HCPC and other community partners to develop innovative strategies for reaching and mobilizing communities of color.	No anticipated changes.

Goal/Priority 7:	**Reduce HIV-related Health Inequalities (cross-cutting)**	
Activities & Sub-activities	**What will be done**	
	Year 1	**Years 2-5**
G/P.7 Address Stigma as a driver of health disparities.	Reducing HIV related stigma to zero in San Francisco is one of GTZ's 3 goals and also one of the initiative's 4 strategies. DPH will continue to support the GTZ Stigma Committee and consider recommendations on how to address stigma among people at risk for and living with HIV, particularly among people of color. A campaign to promote U=U is in development.	No anticipated changes

Goal/Priority 8:	**Cross-cutting Operational and Foundational Strategies**	
Strategy 8: Develop partnerships to conduct integrated HIV prevention and care planning		
Activities & Sub-activities	**What will be done**	
	Year 1	**Years 2-5**
Activity 8.A: Maintain HIV planning group	Continue to maintain partnership with the HCPC and build Council members' capacity to participate in integrated planning. Write, submit, and disseminate an updated SF EMA Integrated HIV Prevention and Care Plan, incorporate HCPC recommendations. Monitor the SF EMA Integrated HIV Prevention and Care Plan.	No anticipated changes
Activity 8.B: Develop HIV prevention and care networks	Co-develop an integrated prevention and care "roadmap" with the HCPC to guide future funding and services. Conduct extensive community engagement with care and prevention provider networks to give input on the roadmap. Continue to maintain and support GTZ initiatives and subcommittees using the goals and strategies of the initiative as a lens for prioritizing services. SFDPH will continue to engage the HCPC in data-driven planning through annual and as-needed presentations and	Continue to maintain networks during roadmap implementation, to get feedback on what is working and what needs to be changed.

	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.	

Goal/Priority 8: Cross-cutting Operational and Foundational Strategies		
Strategy 9: Implement structural strategies to support and facilitate HIV surveillance and prevention		
Activity 9.A: Ensure data security, confidentiality, and sharing	SFDPH staff and funded contractors are trained in the local SFDPH data and confidentiality standards (which comply with NCHHSTP standards), the CDC security and confidentiality standards and the State Office of AIDS standards at the time of hire and yearly thereafter. SFDPH HIV surveillance maintains secure procedures for data sharing, including D2C activities and use of surveillance data across HIV programs including prevention programs and LINCS within the context of existing laws.	No anticipated changes
Activity 9.B: Strengthen laws, regulations, and policies	The State of California has laws governing how HIV surveillance data is collected and shared in place that have allowed SFDPH HIV surveillance to successful ensure data security, confidentiality and sharing.	No anticipated changes
Activity 9.C: Strengthen health information systems infrastructure	SFDPH is in the process of implementing a new electronic health record (EHR) system for DPH (Go Live is August 3, 2019). The two main hospitals (ZSFG and Laguna Honda Hospital), Ambulatory Care clinics, the Population Health Division clinics, the Public Health Laboratory, and Jail Health Services, and Behavioral Health clinics are undergoing adoption of the new EHR and we are currently in the adoption phase of the build. Representatives from HIV surveillance and HIV prevention have been meeting regularly with this EHR team to assess how the new EHR will enhance public health surveillance, analysis and reporting. We are identifying changes in work flows and resource needs that will support the new EHR when we are live with the new system while taking a critical look at improving our	No anticipated changes

	work flows and becoming more efficient in the work that we do. We are discussing metrics and reporting of standardized data definitions and processes.	
Activity 9.D: Promote expansion of technological advances	SFDPH staff is working with a large community testing site to pilot test a more efficient and secure mechanism using DocuSign for passive HIV case reporting. The pilot will be used to identify reporting issues and inform protocol revisions and roll-out to other passive reporting sites.	After this pilot test, lessons learned will be applied and additional testing sites will be invited to participate in case reporting using Docusign.
Strategy 10: Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities		
Activity 10.A: Conduct data-driven planning for HIV surveillance, prevention, and care activities	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). The scorecards will be used to monitor data at community-based organizations as well as at the population level. In addition, HIV surveillance data will be continued to be analyzed and shared to monitor the impact of local HIV prevention efforts on the population level and to provide a data-driven basis for changes in policies or strategies.	No anticipated changes
Activity 10.B: Conduct data-driven monitoring and evaluation and use findings to continuously improve HIV surveillance and prevention activities	Program-level, strategy-level, and collective impact scorecards have begun to illuminate successes as well as disparities and gaps that need to be addressed. HIV surveillance data is being actively shared with GTZ subcommittees focusing on specific vulnerable populations including the homeless and people who inject drugs and with community prevention partners.	No anticipated changes
Strategy 11: Build capacity for conducting effective HIV program activities, epidemiologic science, and geocoding		
Activity 11.A: Assess capacity-building assistance needs	2018 will be an intensive planning year for SFDPH as it embarks on formative work for an RFP being released in 2019. SFDPH will work closely with CBOs to plan for shifts in HIV prevention strategies and activities. CBA needs will be assessed and CBA plans developed annually thereafter.	No anticipated changes
Activity 11.B: Develop and implement capacity-building assistance plans, including technical assistance	As the new prevention strategies and activities are being developed, SFDPH will continue its communication with its community partners and HCPC and develop trainings to ensure providers are successful in their new ventures.	No anticipated changes

Activity 11.C: Enhance epidemiologic and analytic capacity (e.g., data to care, cluster detection and investigation) and other prevention activities	SFDPH has been conducting Data to Care (DTC) activities as a joint activity between HIV surveillance and the LINCS program since 2012 and DTC activities have increased with CDC PrIDE funding in recent years. Drawing on past experience, we continue to refine and improve our DTC efforts and apply lessons learned in DTC to local Data to PrEP efforts for prevention of HIV. In addition, we will implement HIV-TRACE as a new tool to identify persons of concern who are not virally suppressed and/or who are part of a recent transmission cluster and continually evaluate the utility of this new tool as a prevention activity.	No changes.
Activity 11.D: Enhance geocoding and data linkage capacity	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.	No anticipated changes

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2. Please briefly discuss potential barriers (e.g., environmental, political, social) you anticipate may be encountered when implementing or operating your program.

1) The political landscape is potentially shifting with a new mayor and a new Director of the Department of Public Health. Both have traditionally been supportive of HIV prevention efforts and the need for solid epidemiology, but some political realities and the future are unclear.
2) Component B will be integrated with Component A and will require additional coordination, perhaps a shifting focus.
3) San Francisco is experiencing an increase in the number of homeless and marginally housed persons. At the same time, the number of new HIV diagnosed homeless persons has remained steady in recent years indicating this is a population where efforts to decrease new infections has not been as successful in San Francisco. Unless new strategies can be implemented to address the needs of the homeless population, we may experience increasing infections among the homeless as their population size increases.
4) Demographic and epidemiologic shifts, including for example the out-migration of black/African-American San Franciscans, may require prevention providers to change strategies and learn new skills to outreach this population.

Section 5: Timeline

Use the timeline below to list the project tasks and responsible parties associated with the planning, implementation, and evaluation of your program. Click on the appropriate date box to indicate task timeframes. Project tasks should support the activities described in Section 4.

Project Task (planning, implementation, or evaluation)	Responsible Party	Timeframe for Starting and Ending Activity related Tasks																			
		YEAR ONE 2018-2019				YEAR TWO 2019-2020				YEAR THREE 2020-2021				YEAR FOUR 2021-2022				YEAR FIVE 2022-2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategy 1: Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response																					
Activity 1.A | HIV surveillance: Collect HIV case data, including (but not limited to) data on CD4 cell count, HIV viral load, molecular laboratory test results, vital status, and geocoding																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 1.B | HIV prevention program monitoring & evaluation: Collect data to monitor and evaluate HIV prevention programs																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Strategy 2: Identify persons with HIV infection and uninfected persons at risk for HIV infection																					
Activity 2.A | Conduct HIV testing																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 2.B | Conduct HIV partner services (for new and previously diagnosed persons)																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Strategy 3: Develop, maintain, and implement a plan to respond to HIV transmission clusters and outbreaks																					
Activity 3.A | Identify and investigate HIV transmission clusters and outbreaks																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 3.B | Rapidly respond to and intervene in HIV transmission clusters and outbreaks																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Enter text.	Enter text.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 3.C | Maintain outbreak identification and response plan																					
SFDPH will develop, maintain and submit the outbreak identification plan per the August 29, 2019 deadline.	Susan Scheer							☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ De
Strategy 4: Provide comprehensive HIV-related prevention services for people living with diagnosed HIV infection																					
Activity 4.A | Provide linkage to HIV medical care for persons with newly and previously diagnosed HIV infection identified through HIV testing and partner services																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 4.B | Conduct data-to-care activities																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 4.C | Promote early ART initiation																					

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Project Task (planning, implementation, or evaluation)	Responsible Party	Timeframe for Starting and Ending Activity related Tasks																			
		YEAR ONE 2018-2019				YEAR TWO 2019-2020				YEAR THREE 2020-2021				YEAR FOUR 2021-2022				YEAR FIVE 2022-2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 4.D | Support medication adherence																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 4.E | Promote and monitor HIV viral suppression																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 4.F | Monitor HIV drug resistance																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 4.G | Conduct risk-reduction interventions for PLWH																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 4.H | Actively refer PLWH to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Strategy 5: Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection																					
Activity 5.A | Provide periodic HIV testing and risk screening																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 5.B | Provide screening for PrEP eligibility																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 5.C | Provide linkage to and support for PrEP																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 5.D | Provide risk reduction interventions for HIV-negative persons at risk for HIV infection																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 5.E | Actively refer HIV-negative persons at risk for HIV infection to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Project Task (planning, implementation, or evaluation)	Responsible Party	Timeframe for Starting and Ending Activity related Tasks																			
		YEAR ONE 2018-2019				YEAR TWO 2019-2020				YEAR THREE 2020-2021				YEAR FOUR 2021-2022				YEAR FIVE 2022-2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Enter text.	Enter text.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Strategy 6: Conduct perinatal HIV prevention and surveillance activities (or indicate if opt-out has been approved by CDC)																					
Activity 6.A | Promote universal prenatal HIV testing																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 6.B | Provide perinatal HIV service coordination																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 6.C | Conduct case surveillance for women with diagnosed HIV infection and their infants																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 6.D | Conduct perinatal HIV exposure reporting																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 6.E | Conduct fetal and infant mortality review																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Strategy 7: Conduct community-level HIV prevention activities (or indicate if opt-out has been approved by CDC)																					
Activity 7.A: | Conduct condom distribution programs																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 7.B: | Coordinate and collaborate with syringe services programs																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 7.C: | Conduct social marketing campaigns																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 7.D: | Implement social media strategies																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 7.E: | Support community mobilization																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Strategy 8: Develop partnerships to conduct integrated HIV prevention and care planning																					
Activity 8.A | Maintain HIV planning group																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 8.B | Develop HIV prevention and care networks																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Strategy 9: Implement structural strategies to support and facilitate HIV surveillance and prevention																					
Activity 9.A | Ensure data security, confidentiality, and sharing																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 9.B | Strengthen laws, regulations, and policies																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 9.C | Strengthen health information systems infrastructure																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Project Task (planning, implementation, or evaluation)	Responsible Party	Timeframe for Starting and Ending Activity related Tasks																			
		YEAR ONE 2018-2019				YEAR TWO 2019-2020				YEAR THREE 2020-2021				YEAR FOUR 2021-2022				YEAR FIVE 2022-2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategy 10: Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities																					
Activity 10.A Conduct data-driven planning for HIV surveillance, prevention, and care activities																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 10.B Conduct data-driven monitoring and evaluation and use findings to continuously improve HIV surveillance and prevention activities																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Strategy 11: Build capacity for conducting effective HIV program activities, epidemiologic science, and geocoding																					
Activity 11.A Assess capacity-building assistance needs																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 11.B Develop and implement capacity-building assistance plans, including technical assistance																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 11.C Enhance epidemiologic and analytic capacity (e.g., data to care, cluster detection and investigation) and other prevention activities																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activity 11.D Enhance geocoding and data linkage capacity																					
All tasks are on-going and continued from 2017	Susan Scheer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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II. Evaluation Plan

Section 6: Evaluation Purpose and Users

1. Please briefly describe the intended purpose(s) of the evaluation (e.g., identify areas of the program or approach that need improvement, assess program effectiveness or impacts, assess progress toward desired goals, demonstrate productive use of resources).

The purpose of the evaluation is to assess the implementation and effectiveness of HIV prevention and surveillance activities, to inform programmatic and data priorities as well as continuous quality improvement efforts.

Table 3. Stakeholder Engagement

Name of Person or Organization	Role in the Evaluation	When and How to Engage
HIV prevention CBOs	Submit required data; attend periodic meetings to review aggregate data and make recommendations for improvement	Evaluation data will be provided to CBOs annually during special meetings. CBO representatives will be asked to join the HCPC working groups mentioned above. These groups will review data and develop recommendations for program improvement. [annual and semi-annual]
SFDPH, including sections providing HIV prevention services (e.g., Jail Health, Primary Care)	Submit required data; attend periodic meetings to review aggregate data and make recommendations for improvement	Evaluation data will be presented to interdivisional groups such as the Black/African American Health Initiative steering committee and think tank and the Getting to Zero Initiative. This group and others will review the data ad provide input to the Component A project directors for program improvement. [annual]
Clinicians and laboratories	Report mandated HIV lab results to health department; participate in data quality improvement efforts as needed	We will provide data to our clinical partners through existing meetings onsite in SFHN settings on a quarterly basis. This data will be used by the clinical staff to assess success in clinical settings and to make improvements in the system of services. [quarterly]

In Table 3 below, please list the names of persons, organizations, or entities that have a stake in the PS18-1802 evaluation; what role, if any they will have in the evaluation; and when and how they will be engaged.

Table 3. Stakeholder Engagement

Name of Person or Organization	Role in the Evaluation	When and How to Engage
HIV Community Planning Council	Hear an annual presentation on programmatic data, identify gaps that need to be addressed, and make recommendations for improvement, which will be integrated into the annual Integrated Care and Prevention Plan	Evaluation outcomes will be presented to the HCPC through both regular presentations to the HCPC and smaller working groups of the HCPC. Small groups will review data and develop recommendations with the SFDPH for program improvement. [annual and semi-annual]
Communities and consumers	Engage with SFDPH to help Identify HIV prevention needs of different prioritized populations and give input on strategies for reaching them and providing services	SFDPH will convene meetings of community members and consumers to present data and recommendations and to get feedback and input about the effect of programs in the community. [annual]

2. In Table 4 below, please list the names of persons, organizations, or entities that will be primary users of the evaluation and how they will use the evaluation findings.

Table 4. Primary Users of the Evaluation

Name of Person or Organization	How Evaluation Findings Will Be Used by This Person or Organization
SFDPH	To improve data completeness, accuracy, and timeliness. To update priorities for community-based and clinical HIV prevention; improve delivery of HIV prevention programs.
HIV prevention CBOs	To improve delivery of HIV prevention programs; to develop effective strategies for reaching prioritized populations
HIV Community Planning Council	To set priorities for HIV prevention; to identify and make recommendations for addressing gaps
HIV prevention CBOs	To improve delivery of HIV prevention programs; to develop effective strategies for reaching prioritized populations
Getting to Zero Consortium	To understand SFDPH's contribution to the GTZ collective impact initiative; to identify gaps and strategize how Consortium members can address them

3. In Table 5 below, please list the members of the evaluation team, their titles and organizational affiliations, and their responsibilities on the team, listing the team leader(s) first.

Table 5. Roles and Responsibilities of the Evaluation Team

Name	Title and Organizational Affiliation	Responsibilities
Susan Philip	SFDPH Director of Disease Prevention and Control, Co-Project Lead on	Oversight of SFDPH Clinical HIV, STD and HCV Programs, SFDPH funded navigation (LINCS)

	Component A	and PrEP services, laboratory services
Susan Scheer	SFDPH Director, HIV Epidemiology Section, ARCHES Branch, Co-Project Lead on Component A	Oversight of all HIV and STD epidemiology data, eHARS data reporting and analyses.
Tracey Packer	SFDPH Director of Community Health Equity and Promotion, Co-Project Lead on Component A	Oversight of HIV prevention programs in community-based programs funded by SFDPH, fiscal management of 18-1802.
Annie Vu	Epidemiologist, HIV Epidemiology Section, ARCHES Branch	Oversight of NHM&E data.
Dara Geckeler	Senior Health Educator, CHEP Branch	CHEP Quality Improvement Manager
Nyisha Underwood	Quality Improvement Coordinator, CHEP Branch	Results scorecard development and implementation for Getting to Zero
Oscar Macias	Quality Improvement Team Member, CHEP Branch	Results scorecard development and implementation for HIV prevention programs
John Melichar	Program Implementation and QI Coordinator, CHEP Branch	Coordinate oversight of contracted community-based agencies

Section 7: Local Evaluation Questions, Measures, and Design

1. In Table 6 below, please list a) any local evaluation questions, in addition to the questions presented in the measure tables in Appendix A, you plan to address related to nationally monitored or locally monitored CDC PS18-1802 outputs and outcomes; and b) any evaluation questions you plan to address related to intended outcomes of locally defined sub-activities.

Note: If you do not have any additional questions or measures beyond those that are presented in CDC's PS18-1802 measure tables, then you will not need to complete Table 6. Check this box if you have no additional questions or measures. ☑

Table 6. Local Monitoring and Evaluations Measures			
Outcome	Local M&E Question	Measures	Specifications
Click to enter text.	Click to enter text.	Click to enter text.	Numerator: Click to enter text.
			Denominator: Click to enter text.
Click to enter text.	Click to enter text.	Click to enter text.	Numerator: Click to enter text.
			Denominator: Click to enter text.

2. Please describe the evaluation design(s) (e.g., survey, cross-sectional analysis, longitudinal analysis) you intend to use to address your local evaluation questions.

Evaluation design and methods:

SFDPH will continue to use existing data systems and protocols for data collection, providing technical assistance as necessary to ensure data quality. Routine monitoring, evaluation, and quality improvement of activities is necessary to ensure a successful program. The evaluation will use a variety of methods, depending on the evaluation question and available resources for data collection.

- Process evaluation: will be conducted to measure the outputs identified in Section 5 and their relation to program components. Both quantitative measures and qualitative measures will be used.
- Outcome evaluation: will use both quantitative and qualitative methods to assess integrated HIV surveillance and prevention activities. In addition, population-level HIV indicators will be monitored over time.

The evaluation methods will primarily include a non-experimental design as the program activities are focused at the level of the population. SFDPH is committed to Continuous Quality Improvement (QI) for all of our projects. In addition to our evaluation activities, we will have quarterly QI meetings with key project staff to review progress, evaluation data, and document lessons learned during project

implementation. The meetings will focus on revisions to project protocols, the logic model, detailed work plans, monitoring and evaluation strategies, and/or quality assurance activities as needed based on information from our evaluation activities.

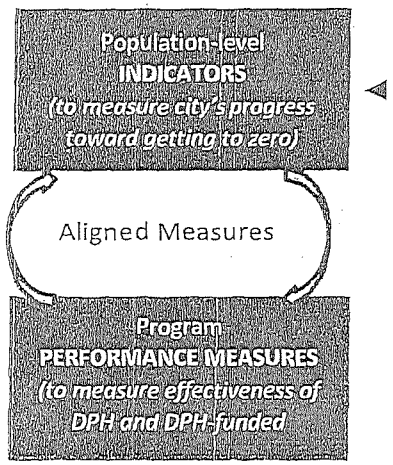
To support QI, SFDPH will use Results-Based Accountability. Results-Based Accountability (or RBA) is "a disciplined way of thinking and taking action that can be used to improve the quality of life in communities, cities, counties, states and nations. RBA can also be used to improve the performance of programs, agencies, and service systems" (Friedman, *Trying Hard Is Not Good Enough*).

The Getting to Zero initiative and the SFDPH are using RBA as the framework for tracking both population-level and program-level results for HIV-related efforts, and showing the link between the work the programs are doing on the ground and the big successes we hope to achieve with HIV – including reducing new transmissions, reducing deaths, and reducing disparities.

The common language we will use to discuss "metrics" is as follows:

Term	Definition	Example
Result	A plain language statement of the goal	No new HIV transmissions
Indicator	A measure that helps quantify the achievement of a result	Number of new HIV diagnoses
Performance measure	A measure of how well a program, agency or service system is working	Number of people on PrEP

In a nutshell, the underlying principle of RBA is if enough programs are doing enough of the "right" thing and doing it well, then changes will happen at the population level – such as reduced transmissions and reduced disparities.



...we should see change here.

If we do well here....

Getting to Zero, in collaboration with SFDPH, will track our collective progress using a web-based platform at clearimpact.com where **we will develop "scorecards" for all programs.** Results, indicators, programs, performance measures and how they all related to each other - as well as the "stories" that help us understand the data – will be maintained.

Table

1. In Table 7 below, please describe how CDC-required surveillance and program data will be collected, what system will be used to enter and manage them at the local level, and how they will be transmitted to CDC (i.e., direct entry into CDC system, such as eHARS or EvaluationWeb; entry into local system and upload into CDC system).

Table 7. Data Collection and CDC Transmission

Data Type	Data Collection Method and Data Management System	Data Transmission Process	Transmission Frequency
HIV case surveillance data	California centralized eHARS	Secure data transfer by California State Office of AIDS	Monthly
HIV geo-coded data	Geocoded data currently are maintained in local secure data network and will be uploaded in California eHARS	Secure data transfer by California State Office of AIDS	Annually
HIV testing data	Keyed or uploaded into EvaluationWeb	Secure data upload	Bi-annually
HIV partner services data	Keyed or uploaded into ISCHTR and uploaded into EvaluationWeb	Secure data upload	Bi-annually
Budget expenditure tables	Keyed into F$P and transcribed to budget forms.	Grants.Gov	Annually

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3. Please describe any feasibility issues you anticipate may interfere with or prevent the collection of data included in the table above.

San Francisco has always provided clean data in a timely fashion and has successfully negotiated any data management or transmission issues with the California, CDC, HRSA or identified subcontractor; no feasibility issues are expected at this time.

4. In table 8 below, please list any delays you anticipate in collecting the data included in Table 7, the reason for the anticipated delays, and any capacity-building assistance you will need to help resolve the delays.

San Francisco does not expect any delays at this time.

Table 8. Data Collection Delays

Delayed Activities	Reason for Data Collection Delay	TA and Capacity Building Needs
Click to enter text.	Click to enter text.	Click to enter text.
Click to enter text.	Click to enter text.	Click to enter text.

5. Please describe how data quality, accuracy, and completeness will be assured and how data quality, accuracy or completeness issues will be resolved prior to transmitting data to CDC.

Quality assurance procedures are in place to ensure surveillance data are accurate and complete. Pre- and post- data entry QA is conducted on all newly reported cases. Monthly data reconciliation is conducted to identify and resolve incomplete or inconsistent data. Quarterly cases are sampled for data re-abstraction from medical records. Data cleanups occur throughout the year based on routine evaluation and analysis of surveillance data using local and CDC developed SAS programs. All data issues and discrepancies are corrected and communicated with staff.

Section 9: Data Management Plan (DMP)

Please describe how HIV prevention and surveillance data will be 1) appropriately managed, secured and remain confidential, 2) reviewed for data quality, and 3) made accessible for public use. Your response should address the following elements in the table below and reference existing standard operating procedures (SOPs) or polices where appropriate. Responses should be specific to data collections funded under PS18-1802 and may be organized and presented by data type or system (e.g., surveillance data (eHARS), prevention program evaluation data (EvaluationWeb direct entry or upload). Please use the table below or the narrative space provided to respond to the required DMP elements.

Note: The DMP must be updated annually and submitted with the Annual Progress Report (APR) or when any significant change is made to a data set or system to ensure that the DMP remains current throughout the lifecycle of the PS18-1802 NOFO. A final DMP must also be submitted at the closeout of PS18-1802.

San Francisco has opted not to use the grid, but submit its Data Management Plan as a narrative.

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PS18-1802 Data Management Plan

Data Steward: Ling Hsu

The San Francisco Department of Public Health (SFDPH) collects, manages and disseminates data for activities funded under PS18-1802 using three primary data systems: Enhanced HIV/AIDS Reporting System (eHARS) for HIV surveillance, Evaluation Web for HIV testing data, the Integrated Surveillance and Clinical Health Tracking Registry (ISCHTR) for partner services, linkage to care, and transmission clusters investigation. The plan for data collection, data standards, data access and archiving is described below and will be evaluated and updated as needed during the project period.

1. Data Collection

1.1. HIV Surveillance

California laws require medical providers and laboratories to report HIV cases and HIV-related test results to the local health departments. SFDPH has the authority to collect case and laboratory reporting data for San Francisco residents diagnosed with HIV and residents of other jurisdictions who receive care in San Francisco. Data collection for HIV case reports and laboratory reports is an ongoing activity that will continue during the PS18-1802 five-year cycle.

1.1.a. HIV Case Reports

SFDPH collects HIV case reports using the San Francisco HIV/AIDS Confidential Case Report Form (CRF) and local variable form (LVF). The CRF includes data elements collected to meet the reporting requirements as well as data elements critical for data analysis that is

consistent with the CDC case report form. The LVF is used to collect and track additional data of local interest such as detailed treatment, housing and care site information. Data collected for HIV surveillance include patient identifiers, demographic and risk information, clinical and laboratory information, date and causes of death, treatment and testing history.
Active HIV surveillance is conducted by HIV surveillance staff reviewing medical records of persons diagnosed with HIV to complete CRF. Case reports are also obtained from passive reporting providers and other health departments. Additional data collection form is developed to collect updated information on previously reported cases through periodic medical chart reviews.

1.1.b. HIV Laboratory Reports

All tests used for diagnosing and monitoring HIV disease are reportable. This includes HIV diagnostic tests, all viral load, CD4 and genotypic tests. The majority of laboratory reports are obtained through electronic laboratory reporting mechanism that allows for more efficient and standardized data reporting and processing.

1.2. Transmission Cluster Investigation

HIV genotyping data collected through routine HIV surveillance will be used to identify transmission clusters. Persons identified as being in a transmission cluster will be referred to the partner services navigators at the STD clinic for outreach and investigation based on criteria for investigation to be determined. Detailed outreach information and results, including assignment, attempts to contact, disposition and current address, will be tracked and managed in ISCHTR until the investigation is closed. Final information including disposition, demographic updates and current address, will be uploaded to eHARS. A plan to respond to a new and growing transmission cluster is being developed using the existing SFDPH emergency preparedness Department Operational Center (DOC) structure.

1.3. Evaluation Web

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Evaluation Web is an online service built by Luther Consulting, LLC to collect and transmit de-identified data to the CDC's National HIV Prevention Program Monitoring and Evaluation (NHM&E) branch for clients seen at CDC-funded sites. Local sites use Evaluation Web to input their HIV testing, risk reduction, and partner services data.

1.3.a. HIV Testing Data

The HIV testing data consist of the client's demographic, self-reported HIV testing history, risk behavior assessment, HIV positive referral services, pre-exposure prophylaxis (PrEP) knowledge and usage, and agency-specific questions. Tests are performed in the community and medical settings and gathered differently based on available resources. In the community, HIV test counselors interviews client to complete the testing form at time of HIV testing encounter. In the medical setting, information for the testing form are pieced together using demographic information from the client's intake and linked to client's laboratory results. Data from HIV surveillance are used to update risk behaviors, previous HIV testing history, and positive referral outcomes.

1.3.b. Partner Services

San Francisco's City Clinic initiates and manages all partner service investigations after a HIV positive result without prior positive testing history is reported. The partner services data are managed in a local database, ISCHTR, which is used to export data into Evaluation Web. Data elements collected include information about index patients and partners' risk behaviors, enrollment status, attempts to locate, and HIV testing referrals.

1.3.c. Risk Reduction Activities

Risk reduction activities are monitored at either the client or aggregate level. Aggregate data are entered directly into Evaluation Web by San Francisco. These data summarize overall numbers of HIV positive persons linked into care, those linked into treatment adherence services, those re-engaged back into medical care, condom distribution, evidence-based interventions, social marketing/public information, those referred to non-occupational post-exposure prophylaxis (PEP) therapy, and men who have sex with men who were

referred and initiated PrEP therapy in a given reporting period.
Data may be reported at the client level, which notes overall enrollment into a specific HIV intervention (summary-level data) or specific interventions at different sessions (session-level data). Data elements collected include client demographics, client risk assessment, and enrollment in HIV Prevention interventions. Session-level data include optional session information and referrals to other services outside of the intervention sessions.

1.4. ISCHTR

ISCHTR is a database developed by the San Francisco STD Control program to manage data on reportable STDs and follow up with patients reported. STD program staff perform partner notification and linkage to care for HIV cases identified in San Francisco, and all data collected through these activities is also recorded in ISCHTR. These data include programmatic data from the investigators (such as attempts made to contact clients) and data from the clients themselves, including demographics, locating information, and histories of sexual practices and other risk factors.
All data collected through an individual investigation are related to a single assignment number, and all assignments for working with as given client are related to a record for that patient.

2. Standards for Data Collection

2.1. HIV Surveillance

Standard data collection forms are used to collect HIV case reports. Any changes are communicated promptly with surveillance staff and passive reporting providers. Laboratory data reporting format and mechanism has been established and validated with each laboratory. HIV case and laboratory data are maintained in eHARS and other ancillary local relational databases. eHARS upgrade and CRF update are implemented according to CDC standards and timelines. Data are routinely reviewed for quality assurance and evaluated to ensure the CDC process and outcome standards for HIV surveillance data are met. Standard Operating Procedures are in place for collection, processing, management and quality assurance of surveillance data.

2.2. Transmission Cluster Investigation

HIV transmission clusters identified from running HIV TRACE will be tracked and managed in ISCHTR following the same standards and procedures used for tracking the results of partner services activities.

2.3. Evaluation Web

The CDC releases data templates for all jurisdictions to implement at local sites. Data may be directly data entered or electronically uploaded. Direct data entry into Evaluation Web is validated at time of entry. Valid responses are controlled by drop-down options and radio buttons. Electronically uploaded data use an import schema to standardize the data values. A feedback report is generated for all uploaded data before committing the file to the database. This report alerts users of possible fatal errors and data abnormalities that are flagged for review. The CDC also sends out semi-annual quality assurance reports that identify data abnormalities outside of those flagged in the feedback report. Further quality assurance is performed on a monthly basis to update positive referral outcomes and surveillance information.

2.4. ISCHTR

Wherever possible data standards are enforced in ISCHTR through code tables defining allowable answers. Staff are instructed in which data must be collected for which patients, and cases are reviewed by supervisory staff for completeness and accuracy. While codes for all items are locally defined, these internal codes have been mapped to many other code sets in order to export files in standard formats. This includes codes for eHARS, Evaluation Web, LOINC, Snomed, and many code sets defined by PHIN. These mappings are part of the database.

3.Data Access and Sharing

3.1. HIV Surveillance

SFDPH HIV surveillance program follows the CDC and California State security and confidentiality standards and requirements to protect the privacy and confidentiality of all HIV surveillance records. Annually the security and confidentiality training is provided to and confidentiality agreements signed by all surveillance staff and authorized staff who have access to surveillance data. The SFDPH Health Officer and Director of the Population Health Division (the overall responsible party) annually certifies the program's compliance with the CDC Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, STD and TB Programs.

Access to HIV surveillance data is limited to authorized SFDPH personnel who have a role in the collection, management and analysis of surveillance data, and using data to support public health action. eHARS is maintained on the California Department of Public Health data server and access control is managed through information technology to protect the data security. eHARS datasets are downloaded daily for data management and analysis. eHARS data are transmitted to CDC by the California Department of Public Health on a monthly basis.

SFDPH HIV surveillance program's Data Release and Sharing Policy covers how and what surveillance data are released. In general, surveillance data are released in aggregate so that no identifying information can be directly or indirectly identified. Aggregate data form includes routinely published HIV surveillance reports, statistical summaries for data presentations, publications in peer-reviewed journals, or data requests for public use. Release of identifiable case information should be assessed and limited to the use for legitimate public health purposes. Identifying surveillance information may be shared with other SFDPH programs, other local, state or federal agencies or corroborating medical researchers to carry out the duties of the agency in disease investigation and control or evaluation of disease burden and outcomes. Before any individual case level data are released, a data sharing agreement should be developed to define the purposes, responsible parties, data elements, data sharing procedures, data security and data disposal plan. Data analysis of surveillance data is conducted using the de-identified datasets and includes only variables needed for analysis. De-identified datasets are encrypted when not in use and deleted when the analysis is completed.

3.2. Transmission Cluster Investigation

Information collected through investigation of transmission clusters will be maintained in ISCHTR will follow the same data access and sharing procedures set for ISCHTR.

3.3. Evaluation Web

All Evaluation Web users are required to be electronically authenticated by the CDC. This process involves presenting photo identification to be verified by a CDC agent. Once a user is approved, they will need to choose a personal pin for a two-step sign-in process to log into the site in addition to their username and password. Users are restricted to viewing data from their own agency. Administrators at the health department can also manage all users' access levels. Once users are no longer active, users are manually removed from the user list.

3.4. ISCHTR

Access to ISCHTR data is limited in many ways to ensure security. Database permissions are tied to each user's Active Directory login;

which must be updated every six months. The database resides behind the department firewall, so there is no access outside of the work site.
Each user in the system is assigned a security level that can restrict the ability to view or alter sensitive data. Access is not granted until the staff member reviews department privacy policy and signs the STD Program oath of confidentiality.
Each patient in ISCHTR is assigned a permanent random ID number that can be used to create de-identified data files. This anonymous number is not accessible to the client or anyone else other than epidemiology staff working with these files.

4.Statement of the use of data standards that ensure all released data have appropriate documentation that describes the method of collection, what the data represent, and potential limitations for use

SFDPH has policies and standards for data collection, quality assurance, and data release that are regularly reviewed and updated. The data release policy includes type of data and how the data may be released. All data requests are reviewed by the program directors or a designee to ascertain the nature of the request and the availability and feasibility of the data requested. The data quality (e.g. completeness and accuracy) and limitations will be assessed before release. Program staff will provide necessary interpretation and clarification to ensure appropriate understanding and use of the data.

5.Data Archiving

5.1. HIV Surveillance

HIV reporting is mandated by California State laws and will continue indefinitely, therefore HIV surveillance registry data including new case reports and previously reported cases are retained indefinitely to enable monitoring the trends of morbidity and mortality and deduplication of persons reported with HIV disease. The hard copies of the case and laboratory reports, however, may be destroyed after a specified time period. SFDPH HIV surveillance program has developed a record retention policy to convert hard copy reports to electronic format. All hard copy records for deceased cases will be destroyed five years after the date of death.

5.2. ISCHTR

ISCHTR data are backed up nightly. Backups are archived weekly and rotated off site. Backup tapes are encrypted with 256-bit security. Tapes are rotated within the month, but the last backup of each quarter is not overwritten until the next year. The last backup for each year is permanently archived.
Backups and restorations are performed by IT staff, and not accessible to other staff.

Section 10: Data Analysis and Reporting

1. Please briefly describe any local analyses you plan to conduct on your HIV surveillance and prevention program data.

   San Francisco will continue to support local planning efforts and support SFDPH, HCPC, government and local organizations and whoever else may request data and analyses to move HIV/STD/HCV efforts forward.

2. Please use Table 10 below to list any reports you plan to produce from your HIV surveillance and prevention program data, beginning with all CDC-required reports.

Table 10. Evaluation Reports

Report Title/Purpose	Primary Target Audience	Purpose of Report	Frequency and Timing of Report
APR	CDC	To report on progress of funded 18-1802 efforts.	Annually
EPMP	CDC	To reflect current planning efforts as well as changes in upcoming years.	Annually
Standard Evaluation Report	CDC	Evaluation of surveillance process and outcome standards	Submit annually in January
Annual Epidemiology Report	Prevention Partners, GTZ, Community-based Organizations, internal SFDPH partners	Data-driven approach for HIV prevention planning. Summary of trends in HIV epidemiology among newly diagnosed and persons living with HIV.	Annually

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Section 11: Data Use

1. Please use Table 11 below to describe how HIV surveillance and prevention program data will be reviewed to monitor your surveillance and prevention activities and improve program performance.

Table 11. Data Monitoring Reviews and Use

Activity Monitored	Data to be Reviewed	Reviewer (Name/Position)	Frequency of Review	Nature of Response
eHARS data quality	Data elements required for reporting or critical for data analysis and evaluation	Surveillance epidemiologist	Monthly	Ensure data quality and resolve data discrepancies
Lab data quality and timeliness	Lab documents	Surveillance	Quarterly	Monitor lab reporting

reports	entered/imported in eHARS	epidemiologist		volume, timeliness, and resolve data discrepancies
Lab report card	Lab data in eHARS	Surveillance epidemiologist	Annually	Provide feedback to reporting laboratories
Routine Interstate Duplicate Review (RIDR)	RIDR linelists and eHARS data	Surveillance coordinator	Twice a year	Resolve interstate duplicates and enter in eHARS to monitor completion

2. Please describe how lessons learned will be identified and summarized for sharing. San Francisco works closely with its partners to share and discuss evaluation measures and how they can improve our work. The SFDPH has developed a strong culture of quality improvement (QI) and has integrated it into all our public health work. Within this QI framework, evaluation data is collected, analyzed, and discussed in collaboration with our partners. The table below describes the partners/stakeholders that not only receive recommendations and lessons learned, but participate in the development of the analysis and development of recommendations. Our use of RBA, as described above, allows for easy sharing of program performance data as well as progress toward overall outcomes. A related online tool, Results Scorecard, provides information access for partners.

3. Please use Table 12 below to describe with whom and how evaluation findings and lessons learned will be shared within the health department, with health department contractors, with other primary users of the evaluation findings, with other health departments, and with other stakeholders and interested audiences.

Table 12. Sharing of Evaluation Findings and Lessons Learned

Audience	Mechanism of Feedback	Frequency of Feedback
SFDPH	During 18-1802 management meetings.	Monthly
HIV prevention CBOs	Program Liaisons will share data back to agencies; data will also be shared at CBO network meetings (e.g., PrEP program coordinators meeting, HIV test coordinators meeting).	Quarterly
HIV Community Planning Council	Presentations to full Council	Semi-annually
Getting to Zero Consortium	Presentations at Steering and Committee meetings	Semi-annually.

Section 12: Human Subjects

If applicable, please describe all program and evaluation activities covered by a Human Subjects Protection/Institutional Review Board approval.

None.

1. If contract support will be used to provide program services or monitoring and evaluation, please use Table 13 below to provide the names of each contractor and to provide a brief description of their required program and evaluation related duties, tasks, and primary deliverables.

   No contractors providing services, monitoring or evaluation are funded under PS18-1802

Table 13. Contract Support for Program or Evaluation Related Activities		
Contract/Contractor for Program Activities	**Description of Duties/Tasks Performed**	**Primary Deliverables**
Heluna Health.	Fiscal Intermediary for Jail Health Services	HIV testing in the jails
Contract/Contractor for Evaluation Activities	**Description of Duties/Tasks Performed**	**Primary Deliverables**
Click to enter text.	Click to enter text.	Click to enter text.
Click to enter text.	Click to enter text.	Click to enter text.

2. Use Table 14 to list Memoranda of Understanding (MOU), Agreements (MOA), or data sharing agreements that you have or will establish to support surveillance and prevention related activities.

Table 14. Memoranda of Understanding, Memoranda of Agreement, or Data Sharing Agreements	
Collaborator or Contributor	**Services or Resources to be Provided**
SFDPH Disease Prevention and Control Branch	HIV/STI testing, linkage to care, partner services, PEP, PrEP continuum of services
SFDPH Microbiology Laboratory	Processing of HIV/HCV/STI specimens

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III. Standards, Targets, and Local Objectives:

Section 14: National Targets and Related Local Objectives for Key CDC-required Indicators

Please insert your yearly objectives (local targets) for the key indicators in Table 15 below.

Note: Measures reflected in the Key CDC Indicators table below use data that CDC will use for reporting or responding to data requests. You will not be able to provide yearly objectives for measures with established standards. Standards must be met annually.

Table 15. Key CDC Indicators

Activity	Output/Outcome	Indicator (Measure)	Yearly CDC Standard	Local Program Objectives						Yearly CDC Target
				Baseline	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	
HIV Surveillance	1.1: Improved completeness, timeliness, and quality of HIV surveillance data (outcome)	**Measure 1.1.1. a.4** (Cause of Death): ≥85% of the deaths that occurred in a year have an underlying cause of death, assessed 24 months after the death year	≥85%							
		Measure 1.1.2: Completeness of Case Ascertainment ≥95% of the expected number of cases for a diagnosis year are reported, assessed 12 months after the diagnosis year	≥95%							
		Measure 1.1.3: Timeliness of Case Ascertainment ≥90% of the expected number of cases for a diagnosis year are reported within six months following diagnosis, assessed 12 months after the diagnosis year	≥90%							
		Measure 1.1.4: Data Quality ≥97% of cases that meet the surveillance case definition for HIV infection for a diagnosis year will have no required fields missing and pass all standard data edit checks (i.e. Person View Status Flag is "A – Active" or "W – Warning"), assessed 12 months after a diagnosis year	≥97%							
		Measure 1.1.5: Risk Factor Ascertainment ≥80% of cases for a report year have sufficient HIV risk factor information to be classified into a known transmission category, assessed 12 months after the report year	≥80%							
		Measure 1.1.6: Intrastate duplicates ≤1% of cases for a report year have duplicate case reports, assessed 12 months after the report year	≤1%							

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Table 15. Key CDC Indicators

Activity	Output/Outcome	Indicator (Measure)	Yearly CDC Standard	Local Program Objectives						Yearly CDC Target
				Baseline	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	
		Measure 1.1.7: Interstate duplicate ≤2% of Routine Interstate Duplicate Review (RIDR) pairs remain unresolved at the end of each six month RIDR cycle, assessed at the end of each cycle	≤2%							
		Measure 1.1.8: CD4 Reporting ≥85% of cases for a diagnosis year have a CD4 test result based on a specimen collected within one month following HIV diagnosis, assessed 12 months after the diagnosis year	≥85%							
		Measure 1.1.9: Viral Load Reporting ≥85% of cases for a diagnosis year have a viral load test result based on a specimen collected within one month following HIV diagnosis, assessed 12 months after the diagnosis year	≥85%							
		Measure 1.1.10: Timeliness of Laboratory Reporting ≥85% of all labs with a specimen collection date in the diagnosis year are loaded in the surveillance system within two months of the specimen collection date, assessed at 12 months after the diagnosis year	≥85%							
		Measure 1.1.11: Nucleotide Sequence ≥60% of cases for a diagnosis year have an analyzable nucleotide sequence, assessed at 12 months after the diagnosis year	≥60%							
		Measure 1.1.12: Antiretroviral History ≥70% of cases for a diagnosis year have prior antiretroviral use history, assessed at 12 months after the diagnosis year	≥70%							
		Measure 1.1.13.a: ≥70% of cases for a diagnosis year have a known value for previous negative HIV test, assessed at 12 months after the diagnosis year	≥70%							
		Measure 1.1.13.b: ≥50% of cases for a diagnosis year with a previous negative HIV test have a valid date of documented negative test result, assessed at 12 months after the diagnosis year.	≥50%							

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Table 15. Key CDC Indicators

Activity	Output/Outcome	Indicator (Measure)	Yearly CDC Standard	Local Program Objectives						Yearly CDC Target
				Baseline	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	
	1.5: Increased ability to describe the geographic distribution of HIV and understand the social determinants of health in relation to HIV and HIV-related health disparities (outcome)	**Measure 1.5.3:** ≥90% of HIV cases are geocoded to the census tract level, assessed 12 months after the diagnosis year	≥90%							
HIV Prevention	1.6 : Improved completeness, timeliness, and quality of HIV prevention program data (outcome)	**Measure 1.6.1:** Percentage of PS18-1802-funded HIV-positive test records submitted to CDC that have all required fields related to linkage to HIV medical care completed and pass all standard data checks		N/A	80%	80%	80%	80%	80%	≥80%
		Measure 1.6.2: Percentage of PS18-1802-funded HIV-positive test records submitted to CDC that have all required fields related to interview for partner services completed and pass all standard data checks		N/A	85%	85%	85%	85%	85%	≥80%
		Measure 1.6.3: Percentage of PS18-1802-funded HIV-positive tests classified as new diagnoses that have been verified by checking the HIV surveillance system		N/A	90%	90%	92%	92%	94%	≥80%
HIV Testing	2.1: Increased HIV testing among persons at risk for HIV infection (output)	**Measure 2.1.1:** Number of PS18-1802-funded HIV tests conducted among persons at risk for acquiring or transmitting HIV infection		N/A	6500	6600	6700	6800	6900	N/A
	2.2: Increased number of persons living with HIV infection who are aware of their HIV status (outcome)	**Measure 2.2.2:** Number of persons with newly diagnosed HIV infection identified through PS18-1802-funded testing (CDC calculated target)		N/A						TBD
		Measure 2.2.3: Of all PS18-1802-funded HIV tests conducted, the percentage of persons with newly diagnosed HIV infection		0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	N/A
		Measure 2.2.4: Of all persons with newly diagnosed HIV infection identified through PS18-1802-funded testing, the percentage provided an HIV test result		N/A	90%	90%	92%	94%	94%	≥90%

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Table 15. Key CDC Indicators

Activity	Output/Outcome	Indicator (Measure)	Yearly CDC Standard	Local Program Objectives						Yearly CDC Target
				Baseline	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	
		Measure 2.2.5: Of all persons living with HIV infection, the percentage who know their HIV-positive status		94%	94%	94%	95%	95%	95%	≥90%
	2.3: Increased identification of HIV-negative persons at risk for HIV infection (output)	**Measure 2.3.1:** Of all PS18-1802-funded HIV tests conducted that had HIV-negative results, the percentage of tests that are among persons at risk for HIV infection		N/A	60%	60%	60%	60%	60%	N/A
Partner Services	**2.4:** Increased participation in HIV partner services among persons with diagnosed HIV infection, identified through PS18-1802-funded testing (outcome)	**Measure 2.4.1:** Of all persons with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage interviewed for partner services		57%	60	65	70	75	80	≥85%
	2.5: Increased participation in HIV partner services among persons with diagnosed HIV infection, identified throughout the jurisdiction (outcome)	**Measure 2.5.1:** Of all persons with newly diagnosed HIV infection reported to surveillance, the percentage reported to the partner services program		99%	99%	99%	99%	99%	99%	N/A
		Measure 2.5.2: Of all persons with newly diagnosed HIV infection reported to the partner services program, the percentage interviewed for partner services in ≤30 days after HIV Diagnosis		60%	65%	70%	70%	70%	70%	N/A
	2.7: Increased notification and HIV testing of partners identified through HIV partner services (output)	**Measure 2.7.2:** Of all named, notifiable partners identified through HIV partner services, the percentage tested for HIV infection		59%	60%	60%	60%	60%	60%	N/A
Identify, Investigate, and Rapidly Respond to Transmission Clusters	**3.2.** Improved response to HIV transmission clusters and outbreaks (outcome)	**Measure 3.2.1:** Of all HIV-positive persons in transmission clusters who were not known to be virally suppressed at the time of identification as part of the cluster, percentage that achieved viral suppression within 6 months of identification as part of the cluster. (NOTE: Program currently determining through a series of pilot tests currently being run if this activity will be carried out. In addition, we are determining what constitutes a 'cluster of concern.' Local program objectives will be determined and likely changed based on findings from these pilot tests).		n/a	10%	20%	30%	40%	60%	≥60%

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		Measure 3.2.2: Of all partners of transmission cluster members who were not known to be HIV positive at the time of cluster identification, percentage tested or re-tested within 6 months of identification as part of the risk network. This activity will only be conducted if there is a true new and growing outbreak.		n/a	tbd	tbd	Tbd	tbd	tbd	TBD

Table 15. Key CDC Indicators

Activity	Output/Outcome	Indicator (Measure)	Yearly CDC Standard	Local Program Objectives						Yearly CDC Target
				Baseline	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	
		Measure 3.2.3: Of all partners of transmission cluster members who were determined to be HIV-negative and not on PrEP, percentage referred for PrEP within 6 months of identification as part of the risk network. This activity will only be conducted if there is a true new and growing outbreak.		n/A	TBD	TBD	TBD	TBD	TBD	TBD
Linkage to and Retention in HIV Medical Care, and Viral Suppression	**4.1:** Increased linkage to and retention in HIV medical care among PLWH (outcome)	**Measure 4.1.5:** Of all person with newly diagnosed HIV infection identified throughout the jurisdiction, the percentage linked to HIV medical care in ≤ 30 days of diagnosis		79%	80%	82%	83%	84%	85%	≥85%
		Measure 4.1.6: Of all persons with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage linked to HIV medical care in ≤ 30 days after HIV diagnosis		N/A	80	80	80	80	85	≥85%
		Measure 4.1.14: Of all persons living with diagnosed HIV infection, the percentage in HIV medical care		80%	80	80	80	80	85	≥90%
		Measure 4.1.15: Of all persons living with diagnosed HIV infection, the percentage retained in HIV medical care		62%	65%	70%	75%	80%	90%	≥90%
	4.5: Increased HIV viral load suppression among PLWH (outcome)	**Measure 4.5.1:** Of all persons living with diagnosed HIV infection, the percentage virally suppressed		74%	75%	80%	80%	80%	85%	≥80%
Risk Reduction and Support Services—HIV-Positive Persons	**4.6:** Increased provision of risk reduction interventions for PLWH (output)	**Measure 4.6.3:** Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing a risk-reduction intervention, the percentage provided or actively referred for a risk-reduction intervention		To be discussed.						≥85%
	4.7: Increased active referral to HIV prevention services for PLWH (output)	**Measure 4.7.1:** Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing, percentage referred to any HIV prevention services		To be discussed.						≥80%

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Risk Reduction and Support Services—HIV Negative Persons	5.6: Increased provision of risk reduction interventions for HIV-negative persons at risk for HIV infection (output)	**Measure 5.6.3:** Of all HIV-negative persons at risk for HIV infection identified through PS18-1802-funded testing who are identified as needing a risk-reduction intervention, the percentage provided a risk-reduction intervention		75	77	79	81	83	85	≥85%

Section 15: Objectives for Locally Monitored CDC Outputs/Outcomes and Locally Defined Measures

Please use Table 16 below to establish and monitor local objectives for 1) CDC specified outputs/outcomes and measures not included in Table 15 above or 2) locally defined outputs/outcomes and measure.

Note: Table 16 is provided as a tool to assist in the monitoring and evaluation of your program; however, it is optional.

San Francisco has not opted to develop any locally defined measures at this time.

Table 16. Local Objectives

Activity	Outputs/Outcomes	Measures	Baseline	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Click to enter text.	Click to enter text.	Click to enter text.	Enter text.	Enter text.	Enter text.	Enter text.	Enter text.	Enter text.
Click to enter text.	Click to enter text.	Click to enter text.	Enter text.	Enter text.	Enter text.	Enter text.	Enter text.	Enter text.
Click to enter text.	Click to enter text.	Click to enter text.	Enter text.	Enter text.	Enter text.	Enter text.	Enter text.	Enter text.
Click to enter text.	Click to enter text.	Click to enter text.	Enter text.	Enter text.	Enter text.	Enter text.	Enter text.	Enter text.
Click to enter text.	Click to enter text.	Click to enter text.	Enter text.	Enter text.	Enter text.	Enter text.	Enter text.	Enter text.

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IV. Glossary of Locally Defined Terms

Please use Table 17 to define all local terms used to describe your program

Table 17. Locally Defined Terms

Term	Guidance	Definition
At risk for HIV		People living with HIV, African-Americans and Latinos prioritizing MSM, trans and cis-gender women, people who inject drugs, and people experiencing homelessness
AHP		Alliance Health Project
ARCHES		Applied Research & Community HIV Epidemiology & Surveillance
BOCC		Business Office: Contract Compliance
CBO		Community-based Organization
CCSF		City and County of San Francisco
GTZ		Getting To Zero
HCPC		HIV Community Planning Council
IFR		Instituto Familiar de la Raza
LINCS		Linkage, Integration, Navigation & Comprehensive Services
LYRIC		Lavender Youth Recreation and Information Center
NIC		Not In Care
PUID		People Who Use Injection Drugs
PWID		People Who Inject Drugs
RAPID		Not an acronym, name for rapid initiation of HIV treatment upon diagnosis.
RFP		Request For Proposals
SFAF		San Francisco AIDS Foundation
SFCHC		San Francisco Community Health Clinic (formerly API Wellness Center)
SFDPH		San Francisco Department of Public Health
PrEP Continuum of Services		PrEP services from outreach and engagement, through linkage to PrEP, PrEP navigation, PrEP initiation and support for retention

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V. Appendix A: PS18-1802 Measure Tables

PS18-1802 Monitoring and Evaluation Questions, Indicators, and Data Sources

Strategy 1: Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
HIV SURVEILLANCE					
1.1: Improved completeness, timeliness, and quality of HIV surveillance data (outcome) 1.1.a: Meet standards detailed in the Technical Guidance for HIV Surveillance Programs for case ascertainment, death ascertainment, risk factor reporting, duplicate review, geocoding, laboratory reporting, timeliness, data quality, completeness, and dissemination, assessed as required by CDC standards (outcome)		**Measure 1.1.1: Death Ascertainment** **Measure 1.1.1.a.1:** Annually link case reports with state/local death certificate data file (or NDI, if state/local death certificate data file is not available) and SSDMF to ascertain dates of deaths that occurred in the previous year and enter or import results into eHARS **Measure 1.1.1. a.2:** Annually link case reports with NDI and state/local death certificate data file to ascertain causes of deaths that occurred 2 years prior to the current year and import results in eHARS **Measure 1.1.1. a.3:** Annually link case reports to state/local death certificate data file (from 2 years ago) to identify unreported cases of HIV infection and enter or import results into eHARS **Measure 1.1.1. a.4** (Cause of Death): ≥85% of the deaths that occurred in a year have an underlying cause of death, assessed 24 months after the death year	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov	NHSS	Aggregate
		Measure 1.1.2: Completeness of Case Ascertainment ≥95% of the expected number of cases for a diagnosis year are reported, assessed 12 months after the diagnosis year	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov Must be met for the population of all cases and for the subset of pediatric cases age <13 years.	NHSS	Person-level

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Strategy 1: Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
		Measure 1.1.3: Timeliness of Case Ascertainment ≥90% of the expected number of cases for a diagnosis year are reported within six months following diagnosis, assessed 12 months after the diagnosis year			
		Measure 1.1.4: Data Quality ≥97% of cases that meet the surveillance case definition for HIV infection for a diagnosis year will have no required fields missing and pass all standard data edit checks (i.e. Person View Status Flag is "A – Active" or "W – Warning"), assessed 12 months after a diagnosis year	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov. Must be met for the population of all cases and for the subset of pediatric cases age <13 years.	NHSS	Person-level
		Measure 1.1.5: Risk Factor Ascertainment ≥80% of cases for a report year have sufficient HIV risk factor information to be classified into a known transmission category, assessed 12 months after the report year			
		Measure 1.1.6: Intrastate duplicates ≤1% of cases for a report year have duplicate case reports, assessed 12 months after the report year	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov.	NHSS	Person-level
		Measure 1.1.7: Interstate duplicate ≤2% of Routine Interstate Duplicate Review (RIDR) pairs remain unresolved at the end of each six month RIDR cycle, assessed at the end of each cycle			
		Measure 1.1.8: CD4 Reporting ≥85% of cases for a diagnosis year have a CD4 test result based on a specimen collected within one month following HIV diagnosis, assessed 12 months after the diagnosis year	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov. Must be met for the population of all cases and for the subset of pediatric cases age <13 years.	NHSS	Person-level
		Measure 1.1.9: Viral Load Reporting ≥85% of cases for a diagnosis year have a viral load test result based on a specimen collected within one month following HIV diagnosis, assessed 12 months after the diagnosis year			

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Strategy 1: Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
		Measure 1.1.10: Timeliness of Laboratory Reporting ≥85% of all labs with a specimen collection date in the diagnosis year are loaded in the surveillance system within two months of the specimen collection date, assessed at 12 months after the diagnosis year			
		Measure 1.1.11: Nucleotide Sequence ≥60% of cases for a diagnosis year have an analyzable nucleotide sequence, assessed at 12 months after the diagnosis year	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov	NHSS	Person-level
		Measure 1.1.12: Antiretroviral History ≥70% of cases for a diagnosis year have prior antiretroviral use history, assessed at 12 months after the diagnosis year			
		Measure 1.1.13: Previous Negative HIV Test **Measure 1.1.13.a:** ≥70% of cases for a diagnosis year have a known value for previous negative HIV test, assessed at 12 months after the diagnosis year **Measure 1.1.13.b:** ≥50% of cases for a diagnosis year with a previous negative HIV test have a valid date of documented negative test result, assessed at 12 months after the diagnosis year.			
1.2: Improved monitoring of trends in HIV infection (outcome)		**Measure 1.2.1: Data Dissemination and Reporting** **Measure 1.2.1.a:** Publish and disseminate an HIV surveillance report annually, per CDC guidance **Measure 1.2.1.b:** Publish and disseminate at least one comprehensive Integrated HIV Epidemiologic Profile during the 5-year funding period, per CDC guidance	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov Must be met for the population of all cases and for the subset of pediatric cases age <13 years	NHSS	NA

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Strategy 1: Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
1.3: Increased use of surveillance and epidemiological data to guide prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services (output)				Monitored locally, data are not reported to CDC	
1.4: Increased use of geocoded data linked to census and social determinants of health datasets to guide prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services (output)				Monitored locally, data are not reported to CDC	
1.5: Increased ability to describe the geographic distribution of HIV and understand the social determinants of health in relation to HIV and HIV-related health disparities (outcome)		**Measure 1.5.1:** Establish a Memorandum of Agreement (MOA) to submit geocoded data to CDC for the 5-year funding period.	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov.	APR, SER	NA
		Measure 1.5.2: On an annual basis, submit geocoded HIV data, for the HIV diagnosis year of interest, to CDC per CDC guidance			
		Measure 1.5.3: ≥90% of HIV cases are geocoded to the census tract level, assessed 12 months after the diagnosis year	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov.	NHSS	Person-level
HIV PREVENTION PROGRAM					
1.6: Improved completeness, timeliness, and quality of prevention program data (outcome)	**Question 1.6.1-1.6.3:** To what extent did grantees improve their ability to provide quality, timely, and complete data for key performance variables	**Measure 1.6.1:** Percentage of PS18-1802-funded HIV-positive test records submitted to CDC that have all required fields related to linkage to HIV medical care completed and pass all standard data checks (NOFO Target: ≥80%)	**Numerator:** Number of HIV-positive test records in the denominator that have all required fields related to linkage to HIV medical care completed and pass all standard data checks	NHM&E	Test-level
			Denominator: Number of PS18-1802-funded HIV-positive test records submitted to CDC		
		Measure 1.6.2: Percentage of PS18-1802-funded HIV-positive test records submitted to CDC that have all required fields related to interview for partner services completed and pass all standard data checks (NOFO Target: ≥80%)	**Numerator:** Number of HIV-positive test records in the denominator that have all required fields related to interview for partner services completed and pass all standard data checks		
			Denominator: Number of PS18-1802-funded HIV-positive test records submitted to CDC		
		Measure 1.6.3: Percentage of PS18-1802-funded HIV-positive tests classified as new diagnoses that have been verified by checking the HIV surveillance system (NOFO Target: ≥80%)	**Numerator:** Number of HIV-positive test records in the denominator that have been verified as new diagnoses by checking the HIV surveillance system		
			Denominator: Number of PS18-1802-funded positive HIV test records submitted to CDC that are classified as new diagnoses		

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Strategy 2: Identify persons with HIV infection and uninfected persons at risk for HIV infection					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
HIV TESTING					
2.1: Increased HIV testing among persons at risk for HIV infection (output)	**Question 2.1.1:** To what extent was there an increase in HIV testing among persons at risk for HIV?	**Measure 2.1.1:** Number of PS18-1802-funded HIV tests conducted among persons at risk for HIV infection	**Count:** Number of PS18-1802-funded HIV tests conducted in which a) the test result was positive or b) the test result was negative and the person tested was determined to be at risk for HIV infection	NHM&E	Test-level
2.2: Increased number of persons living with HIV infection who are aware of their HIV status (outcome)	**Question 2.2.1-2.2.4:** To what extent was there an increase in the number of persons living with HIV infection who are aware of their HIV status?	**Measure 2.2.1:** Number of PS18-1802-funded HIV tests conducted by grantee	**Count:** Number of PS18-1802-funded HIV tests conducted	NHM&E	Test-level
		Measure 2.2.2: Number of persons with newly diagnosed HIV infection identified through PS18-1802-funded testing **(CDC calculated target)**	**Count: TBD**		
		Measure 2.2.3: Of all PS18-1802-funded HIV tests conducted, the percentage of persons with newly diagnosed HIV infection	**Numerator:** Number of HIV tests in the denominator in which the HIV infection was newly diagnosed	NHM&E	Test-level
			Denominator: Number of PS18-1802-funded HIV tests conducted		
		Measure 2.2.4: Of all persons with newly diagnosed HIV infection, the percent provided an HIV test result **(NOFO target: ≥90%)**	**Numerator:** Number of persons in the denominator who are provided their HIV test result	NHM&E	Client-level
			Denominator: Number of persons with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing		
		Measure 2.2.5: Of all persons living with HIV infection, the percentage who know their HIV-positive status **(NHAS and NOFO target: ≥90%)**	**Numerator:** Number of persons in the denominator who are living with diagnosed with HIV infection	NHSS	Person-level
			Denominator: Number of persons in the jurisdiction who are estimated to be living with HIV infection		
2.3: Increased identification of HIV-negative persons at risk for HIV infection (output)	**Question 2.3.1:** To what extent was there an increase in the identification of HIV-negative persons at risk for HIV?	**Measure 2.3.1:** Of all PS18-1802-funded HIV tests conducted that had HIV-negative results, the percentage of tests that are among persons at risk for HIV infection	**Numerator:** Of negative HIV tests in the denominator, the number in which the person tested was at risk for HIV infection	NHM&E	Test-level
			Denominator: Number of PS18-1802-funded HIV tests with negative results		
PARTNER SERVICES—PS18-1802-Funded Testing					
2.4: Increased participation in HIV partner services among persons with	**Question 2.4.1:** To what extent was there an increase in participation in HIV	**Measure 2.4.1:** Of all persons with newly diagnosed HIV infection through PS18-1802-funded HIV	**Numerator:** Number of persons in the denominator who are interviewed for partner services		

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Strategy 2: Identify persons with HIV infection and uninfected persons at risk for HIV infection					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
diagnosed HIV infection, identified through PS18-1802-funded testing (outcome)	partner services among persons with newly diagnosed HIV infection, identified through PS18-1802-funded testing?	testing, the percentage interviewed for partner services (NOFO target: 85%)	**Denominator:** Number of persons with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing		
	Question 2.4.2: To what extent was there an increase in participation in HIV partner services among persons with previously diagnosed HIV infection identified through PS18-1802-funded HIV testing?	**Measure 2.4.2:** Of all persons with previously diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage interviewed for partner services	**Numerator:** Number of persons in the denominator who are interviewed for partner services		
			Denominator: Number of persons with previously diagnosed HIV infection identified through PS18-1802-funded HIV testing		
PARTNER SERVICES—Jurisdiction Wide					
2.5: Increased participation in HIV partner services among persons with diagnosed HIV infection, identified throughout the jurisdiction (outcome)	**Question 2.5.1:** To what extent was there an increase in in participation in HIV partner services among all persons with newly diagnosed HIV infection?	**Measure 2.5.1:** Of all persons with newly diagnosed HIV infection who are reported to surveillance, the percent who are reported to the partner services program	**Numerator:** Number of persons in the denominator who are reported to the partner services program	NHM&E	Client-level
			Denominator: Number of persons with newly diagnosed HIV infection who are reported to surveillance in the 12-month observation period		
	Question 2.5.2- 2.5.3: To what extent was there an increase in expedient HIV partner services interviews among persons with newly diagnosed HIV infection?	**Measure 2.5.2:** Of all persons with newly diagnosed HIV infection who are reported to the partner services program, the percentage interviewed for partner services in ≤30 days after HIV diagnosis	**Numerator:** Number of persons in the denominator who are interviewed for partner services in ≤30 days after HIV diagnosis		
			Denominator: Number of persons with newly diagnosed HIV infection who are reported to the partner services program		
		Measure 2.5.3: Of all persons with newly diagnosed acute or recent HIV infection, the percentage interviewed for partner services in ≤14 days after HIV diagnosis	**Numerator:** Number of persons in the denominator who are interviewed for partner services in ≤14 days after HIV diagnosis		
			Denominator: Number of persons with newly diagnosed acute or recent HIV infection who are reported to the partner services program		
	Question 2.5.4: To what extent was there an increase in participation in HIV partner services among persons with previously diagnosed HIV infection?	**Measure 2.5.4:** Of all persons with previously diagnosed HIV infection who are reported to the partner services program, the percentage interviewed for partner services	**Numerator:** Number of persons in the denominator who are interviewed for partner services		
			Denominator: Number of persons with previously diagnosed HIV infection who are reported to the partner services program		

Strategy 2: Identify persons with HIV infection and uninfected persons at risk for HIV infection					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
2.6: Increased partner elicitation through HIV partner services interviews of index patients with newly diagnosed HIV infection (outcome)	**Question 2.6.1-2.6.2:** To what extent were notifiable partners elicited through HIV partner services interviews of index patients with newly diagnosed HIV infection	**Measure 2.6.1** Average number of notifiable partners named per interviewed index patient with newly diagnosed HIV infection	**Numerator:** Number of notifiable partners named by index patients with newly diagnosed HIV infection	NHM&E	Client-level
			Denominator: Number of index patients with newly diagnosed HIV infection who are interviewed for partner services		
		Measure 2.6.2: Of all persons with newly diagnosed HIV infection interviewed for partner services, the percentage who named ≥1 notifiable partner	**Numerator:** Number of persons in the denominator who named ≥1 notifiable partner		
			Denominator: Number of index patients with newly diagnosed HIV infection who interviewed for partner services		
2.7: Increased notification and HIV testing of partners identified through HIV partner services (output)	**Question 2.7.1-2.7.3:** To what extent was there an increase in notification and HIV testing of partners identified through HIV partner services?	**Measure 2.7.1:** Of all named, notifiable partners identified through HIV partner services, the percentage notified for HIV partner services	**Numerator:** Number of partners in the denominator who are notified of their potential exposure to HIV		
			Denominator: Number of named, notifiable partners identified through HIV partner services		
		Measure 2.7.2: Of all named, notifiable partners identified through HIV partner services, the percentage tested for HIV infection	**Numerator:** Number of partners in the denominator who are tested for HIV infection	NHM&E	Client-level
			Denominator: Number of named, notifiable partners identified through HIV partner services, who are not known to be HIV-positive		
		Measure 2.7.3: Of all notified partners identified through HIV partner services, the percentage tested for HIV infection	**Numerator:** Number of partners in the denominator who are tested for HIV infection		
			Denominator: Number of notified partners identified through HIV partner services who are not known to be HIV-positive		
2.8: Increased number of partners living with HIV infection who are aware of their HIV status (outcome)	**Question 2.8.1:** To what extent was there an increase in the number of partners living with HIV infection who are aware of their HIV status?	**Measure 2.8.1:** Of all partners identified through partner services with unknown HIV status who are tested, the percentage of partners with newly diagnosed HIV infection	**Numerator:** Number of partners in the denominator who are newly diagnosed with HIV infection		
			Denominator: Number of notified partners identified through HIV partner services, not known to be HIV-positive, who are tested for HIV infection		

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Strategy 2: Identify persons with HIV infection and uninfected persons at risk for HIV infection					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
DATA-TO-CARE					
2.9: Improve laboratory reporting to HIV surveillance (output)	Question 2.9: Did grantees meet the criteria for complete reporting of HIV-related test results?	Measure 2.9.1: Meet criteria for complete reporting of all HIV-related test results	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov. See details in the Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2014. HIV Surveillance Supplemental Report 2016; 21(No. 4). http://www.cdc.gov/hiv/library/reports/surveillance/ Published July 2016.	NHSS	NA

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Strategy 3: Develop, maintain, and implement plan to respond to HIV transmission clusters and outbreaks Outcomes					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
3.1: Improved early identification and investigation of HIV transmission clusters and outbreaks (outcome)		Measure 3.1.1: Analyze surveillance and other data using CDC-recommended approaches at least monthly to identify HIV transmission clusters and outbreaks	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov	APR, SER	NA
		Measure 3.1.2: For each cluster of concern identified through analysis of surveillance and other data, submit analysis, investigation, and intervention results to CDC quarterly after identification of cluster until investigation and intervention activities are closed			
3.2: Improved response to HIV transmission clusters and outbreaks (outcome)		Measure 3.2.1: Of all HIV-positive persons in transmission clusters who were not known to be virally suppressed at the time of identification as part of the cluster, percentage that achieved viral suppression within 6 months of identification as part of the cluster (NOFO target ≥60%)	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov	NHSS	Person-level
		Measure 3.2.2: Of all partners of transmission cluster members who were not known to be HIV positive at the time of cluster identification, percentage tested or re-tested within 6 months of identification as part of the risk network	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov	APR, SER	Aggregate
		Measure 3.2.3: Of all partners of transmission cluster members who were determined to be HIV-negative and not on PrEP, percentage referred for PrEP within 6 months of identification as part of the risk network			
3.3: Improved plan and policies to respond to and contain HIV outbreaks (outcome)		Measure 3.3.1: Develop and maintain a plan and capacity for cluster and outbreak detection and response	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov	APR, SER	NA

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Strategy 4: Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH)					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
LINKAGE TO AND RETENTION IN HIV MEDICAL CARE					
Outcome 4.1: Increased linkage to and retention in HIV medical care among PLWH (outcome)		Measure 4.1.1: Publish linkage to care, in HIV medical care, retention in care and viral suppression results using the CDC surveillance definitions in annual reports and epidemiologic profile	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov	NHSS	Aggregate
	Question 4.1.2.-4.1.5 To what extent was there an increase in screening and provision of linkage to HIV medical care navigation services for PLWH identified through PS18-1802-funded HIV testing?	Measure 4.1.2: Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage screened for linkage to HIV medical care navigation services needs (calculated by CDC)	**Numerator:** Number of persons in the denominator who are screened for linkage to HIV medical care navigation services needs	NHM&E	Client-level
			Denominator: Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing		
		Measure 4.1.3: Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for linkage to HIV medical care navigation services needs, the percentage identified as needing these services (calculated by CDC)	**Numerator:** Number of persons in the denominator who are identified as needing linkage to HIV medical care navigation services		
			Denominator: Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for linkage to HIV medical care navigation services needs		
		Measure 4.1.4: Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing linkage to HIV medical care navigation services, the percentage who are provided these services (calculated by CDC)	**Numerator:** Number of persons in the denominator who are provided or actively referred to linkage to HIV medical care navigation services		
			Denominator: Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing linkage to HIV medical care navigation services		
	Question 4.1.2.-4.1.5 To what extent was there an increase in linkage of persons with newly diagnosed HIV infection to HIV medical care?	Measure 4.1.5: Of all person with newly diagnosed HIV infection identified throughout the jurisdiction, the percentage linked to HIV medical care in ≤ 30 days of diagnosis **(NHAS and NOFO target: ≥85%)**	**Numerator:** Number of persons in the denominator who are linked to HIV medical care in ≤ 30 days after HIV diagnosis	NHSS	Person-level
			Denominator: Number of newly diagnosed HIV infection cases reported to surveillance in a diagnosis year		
		Measure 4.1.6: Of all persons with newly diagnosed HIV infection identified through PS18-1802-	**Numerator:** Number of persons in the denominator who are linked to HIV medical care in ≤ 30 days after HIV diagnosis	NHM&E	Client-level

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Strategy 4: Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH)					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
		funded HIV testing, the percentage linked to HIV medical care in ≤ 30 days after HIV diagnosis (NHAS and NOFO target: ≥85%)	**Denominator:** Number of persons with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing		
		Measure 4.1.7: Of all persons with newly diagnosed acute HIV infection identified through PS18-1802-funded HIV testing, the percentage linked to HIV medical care in ≤ 14 days after HIV diagnosis	**Numerator:** Number of persons in the denominator who are linked to HIV medical care in ≤ 14 days after HIV diagnosis		
			Denominator: Number of persons with newly diagnosed acute HIV infection identified through PS18-1802-funded HIV testing		
		Measure 4.1.8: Of all partners with newly diagnosed HIV infection identified through partner services, the percentage linked to HIV medical care in ≤ 30 days after HIV diagnosis	**Numerator:** Number of partners in the denominator who are linked to HIV medical care in ≤ 30 days after HIV diagnosis		
			Denominator: Number of partners with newly diagnosed HIV infection identified through partner services		
		Measure 4.1.9: Of all partners with newly diagnosed with acute or recent HIV infection identified through partner services, the percentage linked to HIV medical care in ≤14 days after HIV diagnosis	**Numerator:** Number of partners in the denominator who are linked to HIV medical care in ≤ 14 days after HIV diagnosis		
			Denominator: Number of partners with newly diagnosed acute or recent HIV infection identified through partner services		
	Question 4.1.7.-4.1.8 To what extent was there an increase in linkage of persons with previously diagnosed HIV infection to HIV medical care?	**Measure 4.1.10:** Of all persons with previously diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage linked to HIV medical care in ≤ 30 days after last HIV test	**Numerator:** Number of persons in the denominator who are linked to HIV medical care in ≤ 30 days after last HIV test	NHM&E	Client-level
			Denominator: Number of persons with previously diagnosed HIV infection identified through PS18-1802-funded HIV testing		
		Measure 4.1.11: Of all persons with previously diagnosed HIV infection who are interviewed for partner services and determined to be not in care, the percent who are linked to HIV medical care in ≤ 30 days of report to partner services	**Numerator:** Number of persons in the denominator who are linked to HIV medical care in ≤ 30 days of report to partner services		
			Denominator: Number of persons with previously diagnosed HIV infection who are determined to be not in care at the time of partner services interview		
	Question 4.1.9-4.1.10: Does the use of NHSS and other data sources increase linkage or	**Measure 4.1.12:** For PLWH identified through data-to-care activities, percentage of presumptively not-in-care PLWH with an investigation	**Numerator:** Number of PLWH in the denominator who were confirmed to be not in care within 60 days after the investigation was initiated	NHSS	Client-level

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Strategy 4: Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH)					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
	re-engagement of not-in-care PLWH in HIV medical care?	initiated during a specified time period, who were confirmed to be not in care within 60 days after the investigation was initiated	**Denominator:** Number of PLWH identified through data-to-care activities as presumptively not in care who had an investigation initiated during a specified time period		
		Measure 4.1.13: For PLWH identified through data-to-care activities, percentage of PLWH confirmed during a specified time period to be not in care, who were linked to HIV medical care within 30 days after being confirmed to be not in care	**Numerator:** Number of PLWH in the denominator who were linked to HIV medical care within 30 days after being confirmed to be not in care		
			Denominator: Number of presumptively not-in-care PLWH identified through data-to-care activities who were confirmed during a specified time period to be not in care		
	Question 4.1.11-4.1.12 To what extent was there an increase in PLWH in HIV medical care?	**Measure 4.1.14:** Of all persons living with diagnosed HIV infection, the percentage in HIV medical care	**Numerator:** Number of PLWH with evidence of an HIV medical care visit (e.g. ≥1 CD4 or VL test result) within a 12-month measurement period in the 12-month observation period		
			Denominator: Number of persons living with HIV infection (same as numerator 2.1.4)		
		Measure 4.1.15: Of all persons living with diagnosed HIV infection, the percentage retained in HIV medical care **(NOFO target: ≥90%)**	**Numerator:** Number of PLWH with ≥ 2 CD4 or VL (or genotype) test results based on specimens collected at least 3 months apart in the 12-month observation period		
			Denominator: Number of PLWH who have lived with diagnosed HIV infection for at least 12 months by the end of the reporting period		
4.2 Increased use of surveillance data to support PLWH throughout the HIV care continuum (output)				Monitored locally, data are not reported to CDC	
TREATMENT AND ADHERENCE SUPPORT					
4.3: Increased early initiation of ART among PLWH (outcome)				Monitored locally, data are not reported to CDC	
4.4: Increased provision of ART medication adherence support for PLWH (output)	**Question 4.4.1-4.4.3:** To what extent was there an increase in screening for and provision of ART medication adherence support services for PLWH who are in need of these services?	**Measure 4.4.1:** Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage screened for ART medication adherence support service needs (calculated by CDC)	**Numerator:** Number of persons in the denominator who are screened for ART medication adherence support service needs	NHM&E	Client-level
			Denominator: Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing		

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Strategy 4: Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH)					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
		Measure 4.4.2: Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for ART medication adherence support service needs, the percentage identified as needing these services (calculated by CDC)	Numerator: Number of persons in the denominator who are identified as needing ART medication adherence support services		
			Denominator: Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for ART medication adherence support service needs		
		Measure 4.4.3: Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing ART medication adherence support services, the percentage who are provided these services	Numerator: Number of persons in the denominator who are provided or actively referred to ART medication adherence support services		
			Denominator: Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing ART medication adherence support services		
VIRAL SUPPRESSION					
Outcome 4.5: Increased HIV viral load suppression among PLWH (outcome)	Question 4.5.1: To what extent was there an increase in HIV viral load suppression among persons living with diagnosed HIV infection?	Measure 4.5.1: Of all persons living with diagnosed HIV infection, the percentage virally suppressed (FOA target: ≥80%)	Numerator: Number of persons in the denominator who are virally suppressed	NHSS	Client-Level
			Denominator: Number of persons living with diagnosed HIV in the jurisdiction		
	Question 4.5.2: Does using HIV surveillance data increase viral suppression among not-in-care PLWH who are linked to or re-engaged in HIV medical care?	Measure 4.5.2: For PLWH identified through data-to-care activities, percentage of PLWH linked to HIV medical care during a specified time period, who achieved HIV viral suppression within six months (180 days) after being linked to care	Numerator: Number of PLWH in the denominator who achieve HIV viral suppression within six months (180 days) after being linked to care		
			Denominator: Number of confirmed not-in-care PLWH identified through data-to-care activities who were linked to HIV medical care during a specified time period		
Risk Reduction and Support Services—HIV-Positive Persons					
4.6: Increased provision of risk reduction interventions for PLWH (output)	Question 4.6.1-4.C.3: To what extent was there an increase in screening for and provision of risk reduction interventions for PLWH	Measure 4.6.1: Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage screened for risk reduction intervention needs (calculated by CDC)	Numerator: Number of persons in the denominator who are screened for risk reduction intervention needs	NHM&E	Client-level
			Denominator: Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing		

Strategy 4: Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH)					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
		Measure 4.6.2: Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for risk reduction intervention, the percentage who are identified as needing an intervention (calculated by CDC)	Numerator: Number of persons in the denominator who are identified as needing risk reduction intervention		
			Denominator: Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for risk reduction intervention needs		
		Measure 4.6.3: Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing risk reduction intervention, the percentage provided an intervention **(NOFO Target: 85%)**	Numerator: Number of persons in the denominator who are provided or actively referred for risk reduction intervention		
			Denominator: Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for and identified as needing risk reduction intervention		
4.7: Increased referral to HIV prevention services for PLWH (output)	Question 4.7.1: To what extent was there an increase in referral to any HIV prevention services for persons with diagnosed HIV infection?	Measure 4.7.1: Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing, percentage referred to any HIV prevention services **(GPRA and NOFO target: ≥80%)**	Numerator: Number of persons in the denominator who are provided or actively referred for any HIV prevention service	NHM&E	Client-level
			Denominator: Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing any HIV prevention service		
4.8: Decreased risk behaviors among PLWH at risk of transmission (outcome)				Monitored locally, data are not reported to CDC	
4.9: Increased screening and active referral of PLWH to essential support services, including healthcare benefits, behavioral health, and social services (output)	Question 4.9.1-4.9.3: To what extent was there an increase in screenings and active referrals of PLWH to essential support services, including healthcare benefits, behavioral health, and social services?	Measure 4.9.1: Of all persons living with diagnosed HIV infection, the percentage screened for essential support services, including healthcare benefits, behavioral health, and social services (calculated by CDC)	Numerator: Number of persons in the denominator who are screened for essential support services, including healthcare benefits, behavioral health, and social services	NHM&E	Client-level
			Denominator: Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing		
		Measure 4.9.2: Of all persons living with diagnosed HIV infection who are screened for essential support services, including healthcare	Numerator: Number of persons in the denominator who are identified as needing essential support services, including healthcare benefits, and/or social services		

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Strategy 4: Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH)					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
		benefits, behavioral health, and social services, the percentage who are identified as needing one or more of these services (calculated by CDC)	**Denominator:** Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for essential support services, including healthcare benefits, behavioral health, and social services		
		Measure 4.9.3: Of all persons living with diagnosed HIV infection who are screened and identified as needing essential support services, including healthcare benefits, behavioral health, and social services, the percentage who are actively referred for one or more of these services	**Numerator:** Number of persons in the denominator who are provided or actively referred for essential support services, including healthcare benefits , and/or social services **Denominator:** Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing essential support services, including healthcare benefits, behavioral health, and/or social services	NHM&E	Client-level

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Strategy 5: Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
5.1: Increased periodic HIV testing and risk screening among persons at risk for HIV infection (output)				Monitored locally, data are not reported to CDC	
PrEP					
5.2: Increased screening of HIV-negative persons for PrEP eligibility (output)	**Question 5.2.1-5.2.4:** To what extent was there an increase in screening of HIV-negative persons for PrEP eligibility?	**Measure 5.2.1:** Of all at risk HIV-negative persons identified through PS18-1802-funded HIV testing and not already on PrEP at the time of testing, the percentage screened for PrEP eligibility	**Numerator:** Number of persons in the denominator who are screened for PrEP eligibility	NHM&E	Client-level
			Denominator: Number of at risk HIV-negative persons not currently on PrEP at the time of PS18-1802-funded HIV testing		
		Measure 5.2.2: Of all at risk HIV-negative persons, identified through PS18-1802-funded HIV testing, not already on PrEP at the time of HIV testing and screened for PrEP, the percentage identified as eligible for PrEP	**Numerator:** Number of persons in the denominator who are eligible for PrEP		
			Denominator: Number of at risk HIV-negative persons not currently on PrEP at the time of PS18-1802-funded HIV testing who are screened for PrEP eligibility		
		Measure 5.2.3: Of all HIV-negative partners identified through partner services and not already on PrEP, the percentage screened for PrEP eligibility	**Numerator:** Number of partners in the denominator who are screened for PrEP eligibility		
			Denominator: Number of HIV-negative partners not currently on PrEP at the time of partner services contact		
		Measure 5.2.4: Of all HIV-negative partners, identified through partner services, not already on PrEP at the time of partner services contact and screened for PrEP, the percentage identified as eligible for PrEP	**Numerator:** Number of partners in the denominator who are eligible for PrEP		
			Denominator: Number of HIV-negative partners not currently on PrEP at the time of partner services contact who are screened for PrEP eligibility		
5.3: Increased referral of persons eligible for PrEP to PrEP providers (outcome)	**Question 5.3.1:** To what extent was there an increase in referrals of PrEP-eligible at risk HIV-negative persons for PrEP?	**Measure 5.3.1** Of all at risk HIV-negative persons identified through PS18-1802-funded HIV testing, who are screened and identified as eligible for PrEP, the percentage referred for PrEP	**Numerator:** Number of persons in the denominator who are referred for PrEP	NHM&E	Client-level
			Denominator: Number of at risk HIV-negative persons screened and identified as eligible for PrEP through PS18-1802-funded HIV testing		
	Question 5.3.2: To what extent was there an increase in referrals of	**Measure 5.3.2** Of all HIV-negative partners identified through partners, who are screened and identified as	**Numerator:** Number of persons in the denominator who are referred for PrEP		

Strategy 5: Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
	PrEP-eligible partners for PrEP?	eligible for PrEP, the percentage referred for PrEP	**Denominator:** Number of HIV-negative partners screened and identified as eligible for PrEP through partner services		
5.4: Increased linkage of persons eligible for PrEP to PrEP providers (outcome)				Monitored locally, data are not reported to CDC	
5.5: Increased prescription of PrEP to persons for whom PrEP is indicated (outcome)					
Risk Reduction and Support Services—HIV Negative Persons					
5.6: Increased provision of risk reduction interventions for HIV-negative persons at risk for HIV infection (output)	**Question 5.6.1-5.6.3:** To what extent was there an increase in screening for and provision of risk reduction interventions for HIV-negative persons at risk for HIV infection and other STDs	**Measure 5.6.1:** Of all HIV-negative persons at risk for HIV infection, the percentage screened for risk reduction intervention needs	**Numerator:** Number of persons in the denominator who are screened for risk reduction intervention needs	NHM&E	Client-level
			Denominator: Number of HIV-negative persons identified through PS18-1802-funded HIV testing who are at risk for HIV infection		
		Measure 5.6.2: Of all HIV-negative persons at risk for HIV infection who are screened for risk reduction intervention, the percentage identified as needing an intervention	**Numerator:** Number of persons in the denominator identified as needing risk reduction intervention		
			Denominator: Number of HIV-negative persons identified through PS18-1802-funded HIV testing who are screened for risk reduction intervention needs		
		Measure 5.6.3: Of all HIV-negative persons at risk for HIV infection who are screened and identified as needing risk reduction intervention, the percentage provided an intervention **(NOFO Target: ≥85%)**	**Numerator:** Number of persons in the denominator who are provided or actively referred for risk reduction intervention	NHM&E	Client-level
			Denominator: Number of HIV-negative persons identified through PS18-1802-funded HIV testing who are screened for and identified as needing risk reduction intervention		
5.7: Decreased risk behaviors among HIV-negative persons at risk for HIV infection and other STDs (outcome)				**Monitored locally, data are not reported to CDC.**	
5.8: Increased screening and active referral of HIV-negative persons at risk for HIV infection to essential support services, including healthcare benefits, behavioral health, and social services (output)	**Question 5.8.1-5.8.3:** To what extent was there an increase in screening and active referral of HIV-negative persons at risk for HIV infection to essential support services, including healthcare benefits,	**Measure 5.8.1:** Of all HIV-negative persons at risk for HIV infection, the percentage screened for essential support services, including healthcare benefits, behavioral health, and social services	**Numerator:** Number of persons in the denominator who are screened for essential support services, healthcare benefits, behavioral health, and social services	NHM&E	Client-level
			Denominator: Number of HIV-negative persons identified through PS18-1802-funded HIV testing who are at risk for HIV infection		

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Strategy 5: Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
	behavioral health, and social services?	**Measure 5.8.2:** Of all HIV-negative persons at risk for HIV infection who are screened for essential support services, including healthcare benefits, behavioral health, and social services, the percentage identified as needing one or more of these services	**Numerator:** Number of persons in the denominator who are identified as needing essential support services, healthcare benefits, behavioral health, and/or and social services		
			Denominator: Number of HIV-negative persons identified through PS18-1802-funded HIV testing who are at risk for HIV infection and screened for essential support services, healthcare benefits, behavioral health, and social services		
		Measure 5.8.3: Of all HIV-negative persons at risk for HIV infection who are screened and identified as needing essential support services, including healthcare benefits, behavioral health, and social services, the percentage who are actively referred to one or more of these services	**Numerator:** Number of persons in the denominator who are provided or activity referred for essential support services, healthcare benefits, behavioral health, and/or social services		
			Denominator: Number of HIV-negative persons identified through PS18-1802-funded HIV testing who are at risk for HIV infection and screened and identified as needing essential support services, healthcare benefits, behavioral health, and/or social services		

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Strategy 6: Conduct perinatal HIV prevention and surveillance activities					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
PRENATAL HIV SCREENING AND REFERRAL					
6.1: Increased HIV screening among pregnant women (output)				Monitored locally, data are not reported to CDC	
6.2: Increased number of pregnant women who are aware of their HIV status (outcome)	**Question 6.2.1:** To what extent was there an increase in the number of pregnant women living with HIV infection who are aware of their HIV status?	**Measure 6.2.1:** Of all pregnant women with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percent provided an HIV test result	**Numerator:** Number of pregnant women in the denominator who are provided their HIV test result **Denominator:** Number of pregnant women with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing	NHM&E	Client-level
6.3: Increased provision of perinatal HIV services or service coordination among pregnant women living with diagnosed HIV and their infants (output)	**Question 6.3.1-6.3.2:** To what extent was there an increase in screening and active referral to prenatal HIV care among pregnant women living with diagnosed HIV infection?	**Measure 6.3.1:** Of all pregnant women identified through PS18-1802-funded HIV testing as newly diagnosed with HIV infection, the percentage screened for prenatal HIV care	**Numerator:** Number of pregnant women in denominator who are screened for prenatal HIV care **Denominator:** Number of pregnant women identified through PS18-1802-funded HIV testing with newly diagnosed with HIV infection	NHM&E	Client-level
		Measure 6.3.2: Of all pregnant women with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing prenatal HIV care, the percentage referred for prenatal HIV care	**Numerator:** Number of pregnant women in denominator who are referred for prenatal HIV care **Denominator:** Number of pregnant women identified through PS18-1802-funded HIV testing with newly diagnosed HIV infection screened for and identified as needing prenatal HIV care	NHM&E	Client-level
6.4. Improved provision or coordination of perinatal HIV services (outcome)				**Monitored locally, data are not reported to CDC**	
PERINATAL HIV CASES AND DATA					
6.5: Improved completeness, timeliness, and quality of HIV surveillance data for pediatric cases and HIV-exposed infants (outcome) 6.5.a: Meet standards detailed in the *Technical Guidance for HIV Surveillance Programs* for pediatric surveillance and Perinatal HIV Exposure Reporting(PHER), assessed as required by CDC standards (outcome)		**Measure 6.5.1: Birth Ascertainment** Annually link women with diagnosed HIV infection reported to surveillance to the state/local birth certificate data file to identify all perinatally exposed infants and infants with HIV infection not reported to surveillance, and enter results into eHARS	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov	NHSS	Person-level

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Strategy 6: Conduct perinatal HIV prevention and surveillance activities					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
		Measure 6.5.2: Perinatal HIV Exposure Reporting (PHER) ≥85% of HIV-exposed infants for a birth year have HIV infection status determined by 18 months of age	See the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov This measure only applies to areas conducting Perinatal HIV Exposure Reporting (PHER)		
6.6: Increased use of surveillance and epidemiological data to guide perinatal prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services (output)				Monitored locally, data are not reported to CDC	
6.7: Increased review of cases demonstrating missed prevention opportunities (output)		**Measure 6.7.1:** Number of cases reviewed to demonstrate missed prevention opportunities	**Count:** Number of cases reviewed to demonstrate missed prevention opportunities	Fetal and Infant Mortality Review (FIMR)	NA
6.8: Reduced perinatally-acquired HIV infection (outcome)		**Measure 6.8.1:** Number of perinatally-acquired HIV infections among persons born in the jurisdiction, by year of birth	**Count:** Number of perinatally-acquired HIV infections among persons born in the jurisdiction, by year of birth	NHSS	Person-level

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Strategy 7: Conduct community-level HIV prevention activities					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
7.1: Increased availability of condoms among persons living with or at risk for HIV infection (outcome)	Question 7.1.1: How many condoms were distributed to persons living with or at risk for HIV infection?	Measure 7.1.1: Number of condoms distributed to persons living with or at risk for HIV infection	Count: Number of condoms distributed to persons living with or at risk for HIV infection	NHM&E	Aggregate
7.2: Increased access to syringe service programs for persons who inject drugs (outcome)	Question 7.2.1: How many syringe service programs are operating in the jurisdiction?	Measure 7.2.1: Number of syringe service programs operating in the jurisdiction	Count: Number of syringe service programs operating in the jurisdiction	APR, EOY	NA
7.3: Increased awareness among members of affected communities regarding potential risk for transmitting or acquiring HIV infection and strategies for reducing these risks (outcome)				Qualitative	
7.4: Reduced stigma and discrimination for persons with diagnosed HIV infection (outcome)					

Strategy 8: Develop partnerships to conduct integrated HIV prevention and care planning		
Output or Outcome	Data Source	Data Type
Outcome 8.1: Increased coordination of, availability of, and access to comprehensive HIV prevention, treatment, and support services	Qualitative	

Strategy 9: Implement structural strategies to support and facilitate HIV surveillance and prevention					
Output or Outcome	M&E Question	Measures/Indicators[1]	Specifications	Data Source	Data Type
9.1: Increased data security, confidentiality, and sharing (outcome)		Measure 9.1.1: Full compliance with NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011): http://www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf	See requirements in the NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011): http://www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf	APR, EOY	NA
9.2: Reduced systemic, legal, regulatory, policy, organizational, operational, social, or cultural barriers to HIV surveillance, prevention, and care (outcome)				Qualitative	

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Strategy 10: Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities					
Output or Outcome	M&E Question	Measures/Indicators	Specifications	Data Source	Data Type
10.1: Increased use of data to plan, monitor, evaluate, and improve HIV surveillance and prevention programs and monitor the impact of local HIV prevention efforts (output)	Question 10.1.1: To what extent did grantees use data to plan, monitor, evaluate, and improve HIV surveillance and prevention programs and monitor the impact of an integrated local HIV prevention efforts?	Measure 10.1.1: Produce a continuum of care analysis using national standards and publish in annual reports and epidemiologic profile.	See guidance available in the National HIV Surveillance System - Technical Guidance, May 2017 available at https://partner.cdc.gov.	NHSS	NA
10.2: Increased coordination and integration of comprehensive HIV prevention and care services (outcome)				Qualitative	
10.3: Improved targeting of HIV testing, prevention and care resources, funding, and services (outcome)	Question 10.3.1: To what extent did the grantees improve targeting of HIV testing, prevention and care resources, funding, and services?	Measure 10.3.1: Of all HIV PS18-1802-funded HIV tests conducted, the percentage of tests that were among persons at risk for HIV infection	Numerator: Number of test in the denominator in which a) the test result was positive or b) the test result was negative and the person tested was determined to be at risk for HIV infection Denominator: Number of PS18-1802 funded test conducted	NHM&E	Client-level
10.4: Improved targeting, prioritization, and effectiveness of funded HIV prevention activities (outcome)				Qualitative	
10.5: Improved targeting of HIV programs to address HIV-related health disparities (outcome)				Monitored locally, data are not reported to CDC	

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Strategy 11: Build capacity for conducting effective HIV program activities, epidemiologic science, and geocoding		
Output or Outcome	Data Source	Data Type
Output 11.A: Increased capacity building support and TA provided within the jurisdiction (including CBOs and other partners)	Qualitative	
Output 11.B: Increased jurisdictional capacity to conduct HIV surveillance activities (including D2C activities) and provide HIV prevention services		
Output 11.C: Enhanced capacity to geocode, manage, link, and integrate surveillance and other data for surveillance, prevention, and care		
Outcome 11.1: Strengthened interventional surveillance and response capacity	Monitored locally, data are not reported to CDC	
Outcome 11.2: Enhanced knowledge of the influence of social determinants on risk for disease and continuum of care outcomes		

VII. Appendix B: CDC Defined Terms

Appendix B. CDC Defined Terms	
Term	**Definition**
Active referral	This involves efforts beyond passive referral, in which the individual is only given contact information for the service(s) and is left to make their own contact. There are varying types of *active* referral. Active referral may include but is not limited to activities for the client such as: making appointments, providing transportation, using a case manager or peer navigator to help with access to services, providing the organization to which the client is referred with information collected about the client (including the professional assessment of the client's needs), a "warm hand-off" – such as a 'live' three way conversation (individual/organization making the referral, individual/organization receiving the referral, and the client) – in person or by telephone – in which the client is introduced, and providing explanations about what has already been done to assist the client and reason for referral.
Acute HIV infection	This term refers to the interval between the appearance of detectable HIV RNA and the first detection of anti-HIV antibodies. It is identified when a screening test that detects HIV antigen or antibody is reactive/positive, a supplemental test that detects only IgG antibody is nonreactive/negative, and a NAAT test for HIV viral RNA is reactive/positive. Its duration is variable and depends on the characteristics of the test being used for screening and the supplemental test being used to document infection. "Alternatively, acute HIV infection may be identified when a screening test is nonreactive/negative for HIV antibody, and a NAAT test for HIV RNA is reactive/positive (i.e., in the absence of a result from a supplemental test that detects only IgG antibody)." For further discussion, see: *CDC (2104). Laboratory Testing for the Diagnosis of HIV Infection: Updated Recommendations.* http://www.cdc.gov/hiv/pdf/HIVtestingAlgorithmRecommendation-Final.pdf
Analyzable nucleotide sequence	A nucleotide sequence (the genetic code for a person's HIV strain) that includes valid information that can be analyzed and interpreted.
Anti-retroviral therapy (ART) medication adherence support services	Any intervention that is client-centered and provides support and assistance to HIV-diagnosed persons to improve medication adherence to ART. ART adherence interventions may involve any of the following elements: an educational/behavioral/motivational component, personal adherence counseling, skills-building, tools for better medication management and ongoing support, and/or treatment delivery methods or monitoring devices to facilitate adherence. These programs may be implemented by HIV/AIDS service/health-care providers or pharmacists. A list of evidence based ART adherence interventions may be found at: https://effectiveinterventions.cdc.gov
Behavioral health	Behavioral health is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and the provision of treatments and services for substance misuse, addiction, substance use disorders, mental illness, and/or mental disorders.

Appendix B. CDC Defined Terms	
Term	**Definition**
Capacity Building	Activities that strengthen the core competencies of an organization and contribute to its ability to develop and implement an effective HIV prevention intervention and sustain the infrastructure and resource base necessary to support and maintain the intervention.
Condom distribution	The means by which condoms are transferred, disseminated, or delivered from a community resource (e.g., health department, community-based organization, or health care organization).
Data to Care (D2C) activities	Data to Care (D2C) is a public health strategy that uses HIV surveillance and other data to support the HIV Care Continuum by identifying persons living with HIV who are in need of HIV medical care and services and facilitating linkage to these services. Example applications include (but may not be limited to) identifying persons living with HIV who are: 1) Not in HIV medical care, and providing linkage to care or re-engagement in care services, 2) In HIV medical care, but have sustained high HIV viral load, and provide needed care and social support services or 3) pregnant women or mothers and their exposed infants who may need coordinated services (perinatal HIV services coordination). Additional information is available at https://effectiveinterventions.cdc.gov
Duplicate case reports	A person with more than one state-assigned case number in the surveillance database. This does not include cases where a person was exposed to HIV as an infant, but then became infected with HIV later in life. These people should have two state-assigned case numbers.
Employment assistance services	Programs that provide employment assistance, such as skills assessment, vocational training, employment referrals, job placement, and resume building support. Programs that provide employment assistance including vocational trainings, employment referrals, job placement, skills assessment, resume building support etc.
Essential support services	A service or intervention aimed at reducing risk for transmitting or acquiring HIV infection by modifying a factor (e.g., housing, transportation, employment assistance, and education) or combination of factors that can contribute to risk (e.g., healthcare benefits, behavioral health (see definition for behavioral health), and other medical and social services.
Geocoded data	Data that result from the computational process of transforming a description of a location (textual information on addresses) to a location on the Earth's surface (spatial representation in numerical coordinates).
Healthcare benefits services	Programs that help uninsured or under-insured clients enroll in public or private healthcare benefit programs. Services may include, but are not limited to outreach and education on available health benefit options (e.g., private insurance, health maintenance organizations, Medicaid, Medicare, medication assistance programs), eligibility assessment, and assistance with enrollment. Programs that help uninsured clients enroll in public or private healthcare benefits. Services may include outreach and education on available insurance options, eligibility assessment, enrollment etc.

Appendix B. CDC Defined Terms	
Term	**Definition**
HIV screening	A testing strategy that involves testing persons with no signs or symptoms of HIV infection, regardless of whether they have a recognized behavioral risk for HIV infection. A testing strategy that involves testing persons regardless of whether they have a recognized behavioral risk or symptoms of disease infection. This might be accomplished by testing all persons in a defined population or by selecting persons with specific population-level characteristics (e.g., demographic, geographic area).
HIV surveillance case definition	Public health surveillance requires specific case definitions. The definition of a diagnosis of HIV infection for surveillance purposes has changed over time. Reports of diagnoses of HIV infection must satisfy laboratory and clinical criteria included in the Revised Surveillance Case Definition for HIV Infection — United States, 2014, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6303a1.htm. The case definition will continue to be updated, as needed, to ensure the most accurate monitoring of HIV disease.
HIV test event	An HIV test event refers to a sequence of one or more individual tests conducted to determine a person's HIV status. A test event may consist of a single individual test (e.g., one point-of-care rapid test or one laboratory-based test) or more than one individual tests (e.g., one point-of-care rapid test followed by a laboratory-based supplemental test to determine a final result). A test event may involve more than one face-to-face interaction over more than one day. In EvaluationWeb, a test event is associated with a single unique HIV test form identification number.
HIV transmission clusters	A group of HIV-infected persons (diagnosed and undiagnosed) who have a direct or indirect epidemiological connection related to HIV transmission. A transmission cluster can be detected through multiple mechanisms, including analysis of molecular HIV surveillance data or case surveillance data.
HIV-negative person	A person who has a negative test result based on the most recent HIV test conducted.
Housing services	Programs that help clients find adequate temporary or long-term housing (e.g., providing assistance with finding temporary shelter or housing, finding rental housing, home-buying, assessing eligibility for and making referrals to HUD/HOPWA programs).
In HIV medical care (prevention programs)	Evidence that a client/patient has seen a medical care provider at least once in the past 6 months for HIV treatment
In HIV medical care (surveillance)	Evidence of an HIV medical care visit (e.g. ≥1 CD4 or VL test result) within a 12-month measurement period.
Interviewed for partner services	Indicates whether or not a client was interviewed for the purpose of HIV partner services by health department specialists or non-health department providers trained and authorized to conduct partner services interviews on behalf of the health department. Non-health department providers include public health providers who are 1) collecting data on behalf of the health department and 2) provide information to the health department for partner services follow-up. Interviews conducted by providers other than health department specialists are counted only if they can be verified (i.e., interview results are documented in writing and reported to the health department).

Appendix B. CDC Defined Terms	
Term	**Definition**
Linkage to care (surveillance)	A person is considered to be linked to HIV medical care if there is ≥1 CD4 or viral load test result based on a specimen collected ≤ 1 month following initial diagnosis. See definition in the Continuum of HIV Case: Guidance for Local Analyses Updates, September 2016, available at https: partner.cdc.gov.
Linkage to HIV medical care within 30 days of diagnosis (prevention program)	This occurs when a patient is seen by a health care provider (e.g., physician, a physician's assistant, or nurse practitioner) to receive medical care for his/her HIV infection, usually within a specified time. Linkage to medical care can include specific referral to care service immediately after diagnosis and follow-up until the person is linked to long-term case management. Linkage may be based on HIV-related laboratory tests or other methods of verification. Services may include evaluation of immune system function and screening, treatment, and prevention of opportunistic infections.
Linkage to PrEP provider	The process through which a person at risk for becoming infected with HIV is helped to access a healthcare provider who offers evaluation and management of pre-exposure prophylaxis (PrEP). This is often an active process (e.g., providing transportation, accompanying the person to the appointment, having multiple contacts with the person to support them in accessing the PrEP provider). Linked to a PrEP provider refers to the outcome of the referral or linkage of a PrEP eligible person to a PrEP provider, as indicated by the person's attendance of the first appointment.
Linked to HIV medical care	This term refers to the outcome resulting from referral or linkage of a person living with HIV (PLWH) to HIV medical care. A PLWH is considered to be linked to HIV medical care if they are seen by a healthcare provider (e.g., physician, physician assistant, nurse practitioner) after HIV diagnosis for evaluation and management of their HIV infection. Determination of linkage status may be based on report from a healthcare provider, medical record review, review of other records or databases, reported HIV-related laboratory tests, filling of a prescription for anti-retroviral medication, or client/patient self-report. Linked to HIV medical care refers to the outcome that results from referral or linkage of a patient to care, as indicated by the patient's attendance at the first HIV care appointment. Services during the visit may include evaluation of immune system function and screening, treatment, and prevention of opportunistic infections. For definitions of linkage and linked, consult: https://effectiveinterventions.cdc.gov
Insurance navigation and enrollment services	Programs that help uninsured clients enroll in public or private healthcare insurance. Services may include outreach and education on available insurance options, eligibility assessment, enrollment etc.
Medication adherence support services	CDC-supported medication adherence interventions that improve medication adherence and/or viral load among HIV patients who have been prescribed (antiretroviral treatment). These include: HEART, Partnership for Health (Medication adherence), Peer Support, and SMART Couples.
Mental health services	Programs that are provided by a mental health professional. Services may include psychiatric assessment, consultation, treatment, psychotherapy, crisis intervention etc. See definition of behavioral health for more information

Appendix B. CDC Defined Terms	
Term	**Definition**
Newly diagnosed HIV infection	HIV infection in a person who: (1) does not self-report having previously tested positive for HIV; (2) has not been previously reported to the surveillance system as being infected with HIV; and 3) has no previous evidence of HIV infection in other records or databases.
Newly identified HIV-positive partner	A partner who a) has not previously been reported to the health department as being infected with HIV, b) has not been identified via record review as being previously positive, c) does not self-report having previously tested positive for HIV infection, and d) tested positive for HIV by the health departments or providers.
Notifiable partners	Notifiable partners are named partners that can be located and are determined to be eligible for notification of potential exposure. Partners out of jurisdiction, deceased, known to be previously diagnosed with HIV infection, or for which there is a risk of domestic violence are not considered notifiable.
Not-in-care (NIC)	Refers to a person living with HIV (PLWH) who has never been linked to HIV medical care (never in care) or was previously in HIV medical care but has not attended an HIV medical care appointment in a specified period of time (out of care). The length of time used to determine whether a PLWH is out of care may vary among jurisdictions.
Partner services	Partner services are a broad array of services that should be offered to persons with HIV infection, syphilis, gonorrhea, or chlamydial infection and their partners. A critical function of partner services is partner notification, a process through which infected persons are interviewed to elicit information about their partners, who can then be confidentially notified of their possible exposure or potential risk. Other functions of partner services include behavioral risk-reduction counseling; testing for HIV and other sexually transmitted infections (STIs); hepatitis testing and vaccination; treatment or linkage to medical care for HIV, STIs, and hepatitis; and linkage or referral to other services (e.g., pre-exposure prophylaxis [PrEP] and post-exposure prophylaxis [PEP]; risk-reduction interventions; case management; health benefits navigation; mental health and substance use treatment; transportation and housing services; other social and legal services).
Partners named	Partners named are sexual and injection drug using partners the index patient has had during the interview period, for which the index patient can provide identifying information (e.g., an actual name, an alias, or enough descriptive information that he/she can reasonably be considered identifiable) and sufficient information that he/she can reasonably be considered locatable. This is equivalent to the term "partners initiated" used in the STD Program Operations Guide. This does not include any associates that the partner may name. The amount of information that deems a partner locatable is defined by the jurisdiction (this may include a specific e-mail address or chat room communication).
Partners notified	Denotes sexual or drug using partners notified by health department staff through health department referral, referral after notification attempt by an index patient fails (i.e., contract referral), or referral by the index patient and health department staff together (i.e., dual referral). A sex or drug-injection partner who has been notified of his or her possible exposure to HIV or other sexually transmitted infections (STIs).

Appendix B. CDC Defined Terms

Term	Definition
Persons at risk for HIV infection	Groups or populations can be described as "vulnerable" or "key" or "groups [populations] at risk" if they are subject to societal pressures or social circumstances or engage in behaviors that make them vulnerable to HIV.
Pre-exposure prophylaxis (PrEP)	The use of antiretroviral medication by persons who are not infected with HIV, but are at substantial risk for infection, to reduce their risk for becoming infected.
PrEP eligibility	Refers to a person's status with regard to whether or not he or she meets appropriate criteria for using pre-exposure prophylaxis (PrEP); specifically, whether or not he or she is HIV-negative and at substantial risk for HIV, as defined by CDC in its guidelines for PrEP (*U.S. Public Health Service (2014). Pre-exposure Prophylaxis for HIV Prevention in the United States - 2013: A Clinical Practice Guideline.* http://www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf)
PrEP provider	A healthcare professional (e.g., physician, advanced practice nurse, physician assistant) who conducts evaluations for pre-exposure prophylaxis (PrEP) eligibility and clinical appropriateness, prescribes PrEP, and provides comprehensive management of persons taking PrEP. PrEP providers are peers, volunteers, and staff members of clinics, health departments, and community-based organizations. Patient navigators may be lay persons, paraprofessionals, or medical professionals (e.g., RNs, LPNs).
PrEP screening	The process of conducting an initial assessment regarding a person's eligibility for pre-exposure prophylaxis (PrEP) (i.e., HIV testing and behavioral risk screening) and determining whether or not a more thorough evaluation is warranted. For further discussion on PrEP screening, see: *U.S. Public Health Service (2014). Pre-exposure Prophylaxis for HIV Prevention in the United States - 2013: A Clinical Practice Guideline.* http://www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf
Prescribed PrEP	Refers to a person who has been adequately evaluated and received a prescription for pre-exposure prophylaxis (PrEP). http://www.cdc.gov/hiv/pdf/guidelines/PrEPguidelines2014.pdf
Prevalence	The total number of cases of a disease or behavior in a given population at a particular point in time. HIV prevalence refers to persons living with HIV, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease. Another measure is an estimate of persons at risk for infection because of certain behaviors at a point in time.
Prevention services for HIV-negative persons	A broad array of services for HIV-negative persons living at risk for HIV infection to help them reduce their risk for acquiring HIV infection. These include services to help HIV-negative persons with the following: 1) periodic HIV testing and risk screening; 2) screening for PrEP eligibility; 3) linkage to and support for PrEP; 4) adopting and maintaining safer behaviors to reduce their risk for HIV transmission (e.g., risk reduction interventions); and 5) essential support services to address factors that affect their ability to access and remain in care and to achieve and maintain viral suppression (e.g., healthcare benefits, behavioral health, and social services). See definitions for essential support services, healthcare benefits, behavioral health, and social services

Appendix B. CDC Defined Terms	
Term	**Definition**
Prevention services for HIV-positive persons	A broad array of services for persons living with HIV (PLWH) to help them reduce their risk for transmitting HIV. These include services to help PLWH with the following: 1) linkage to, re-engagement in, and retention in HIV medical care (e.g., linkage and navigation services); 2) achieving and maintaining viral suppression (e.g., early ART initiation, ART medication adherence support services, monitor HIV viral suppression, and monitor HIV drug resistance); 3) adopting and maintaining safer behaviors to reduce their risk for HIV transmission (e.g., HIV risk reduction interventions); and 4) essential support services to address factors that affect their ability to access and remain in care (e.g., healthcare benefits, behavioral health, and social services). See definitions for essential support services, health care benefits, behavioral health, and social services
Previously diagnosed HIV infection	HIV infection in a person who 1) self-reports having previously tested positive for HIV or 2) has been previously reported to the health department surveillance system as being infected with HIV, or 3) has previous evidence of HIV infection in medical or other records or other databases.
Post-exposure prophylaxis (PEP)	Short-term antiretroviral prophylactic treatment provided to the client immediately (as soon as possible, but no more than 72 hours after exposure) to reduce the likelihood of HIV infection after potential exposure.
Re-engagement in HIV medical care	The process through which persons living with HIV (PLWH), who have previously received medical care for their HIV infection but are no longer receiving care, are helped to re-enter HIV medical care. This is often an active process (e.g., providing transportation, accompanying the PLWH to the appointment, having multiple contacts with the PLWH to support them in re-entering medical care). Determination of re-engagement status may be based on report from a healthcare provider, medical record review, review of other records or databases, reported HIV-related laboratory tests, filling of a prescription for anti-retroviral medication, or client/patient self-report.
Referral	Directing clients to a service in person or through telephone, written, or other form of communication. Generally, a one-time event. Referral may be made formally from one clinical provider to another, within a case management system by professional case managers, informally through support staff, or as part of an outreach service program.
Referral to PrEP provider	Referral to PrEP providers is a process involving the provision of information on who the providers are, what documents referred person should take with them, how to get to the providers' agency, and what to expect from the referral process. It is important that the agency that provides PrEP screening services tracks the referral and provides the necessary follow-up to verify the person attended the first appointment with the PrEP provider. A person can be referred to a PrEP provider internally (to another unit or person within the same agency) or externally (e.g. a CBO may screen and identify eligible persons, and then refer them to a healthcare provider that offers PrEP services).

Appendix B. CDC Defined Terms	
Term	**Definition**
Retention in care	A person is considered to have been retained in continuous HIV medical care during the specified 12-month period if he or she had ≥2 CD4 or VL test results based on specimens collected at least 3 months apart in that 12-month observation period. A nucleotide sequence test result may also be used to indicate a care event. See definition in the Continuum of HIV Case: Guidance for Local Analyses Updates, September 2016, available at https: partner.cdc.gov.
Risk Behaviors	Behaviors that can directly expose persons to HIV or transmit HIV, if the virus is present (e.g., sex without a condom, sharing unclean needles). Risk behaviors are actual behaviors by which HIV can be transmitted, and a single instance of the behavior can result in transmission.
Risk reduction intervention	In the context of HIV prevention, a risk reduction intervention is a specific activity (or set of related activities) intended to reduce the risk for HIV transmission or acquisition. HIV risk reduction interventions may be structural, biomedical (e.g., treatment as prevention, pre-exposure prophylaxis [PrEP], post-exposure prophylaxis [PEP]) or behavioral (e.g., improve medication adherence for ART or PrEP, encourage linkage or re-engagement to HIV medical care, and promote HIV testing and PrEP screening and uptake), have protocols outlining steps for implementation, and have distinct process and outcome objectives. Examples of risk reduction interventions may be found at https://effectiveinterventions.cdc.gov
Social Services	Social services includes housing, transportation, domestic violence intervention, and employment.
Substance misuse treatment and services	Drug and alcohol misuse treatment and support programs/services. See definition of behavioral health for more details.
Transportation services	The client received referral to agencies providing transportation assistance (e.g., through direct transportation services, vouchers or tokens) for transportation to and from HIV prevention and medical care appointments.
Viral suppression	A person is considered to have a suppressed viral load if the most recent test result during the specified 12-month observation period was <200 copies/mL. See definition in the Continuum of HIV Case: Guidance for Local Analyses Updates, September 2016, available at https: partner.cdc.gov.

Upload #7

Applicant:	San Francisco Department of Public Health
Application Number:	NU62PS2018003083
Project Title:	San Francisco Dept of Public Health High Impact Prevention
Status:	Submitted
Document Title:	PS18-1802 Component A Budget Justification

San Francisco Department of Public Health, SF Division
HIV Prevention Section, Community Health Equity and Promotion
PS18-1802 Integrated HIV Surveillance and Prevention Programs for Health Depts.
Component A HIV Prevention Budget
01/01/2019-12/31/2019

A. Salaries	$1,106,801
B. Mandatory Fringe	$498,059
C. Consultant Costs	$0
D. Equipment	$0
E. Materials and Supplies	$17,000
F. Travel	$12,784
G. Other Expenses	$43,000
H. Contractual	$2,244,738
Total Direct Costs	**$3,922,382**
I. Indirect Costs (25% of Total Salaries)	$276,700
TOTAL BUDGET	**$4,199,083**

B-AP 1

A. SALARIES $1,106,801

Position Title and Name	Annual	Time	Months	Amount Requested
Director, Population Health Division, and Principal Investigator (PI) T. Aragon, MD, DrPH	NA		12	In-Kind
Deputy Director, Population Health Division C. Siador, MPH	NA		12	In-Kind
Director, Disease Prevention and Control S. Philip, MD, MPH	NA		12	In-Kind
Manager II T. Packer	$142,764	50%	12 months	$71,382
Health Program Coordinator III J. Melichar	$114,110	50%	12 months	$57,055
Senior Health Educator D. Geckeler	$113,574	75%	12 months	$85,180
Health Program Coordinator III J. McCright	$114,110	95%	12 months	$108,404
Health Educator N. Underwood	$105,540	45%	12 months	$47,493
Health Program Coordinator II T. Knoble	$101,951	100%	12 months	$101,951
Health Program Coordinator I Vacant	$89,579	50%	12 months	$44,790
Health Program Coordinator I T. Ick	$89,579	100%	12 months	$89,579
Health Worker II TBD	$69,012	50%	12 months	$34,506
Health Worker II TBD	$69,012	40%	12 months	$27,605
Management Assistant B. Chan Lew	$90,516	50%	12 months	$45,258
Health Program Coordinator II B. Ivory	$101,951	75%	12 months	$76,463
Health Educator H. Hjord	$105,540	90%	12 months	$94,986
Health Worker III Vacant	$75,494	75%	12 months	$56,620
Epidemiologist II J. Chin	$115,770	45%	12 months	$52,096

Health Program Coordinator I O. Macias	$89,579	100%	12 months	$89,579
Health Educator M. Paquette	$105,540	10%	12 months	$10,554
Principal Admin Analyst TBD	$132,989	10%	12 months	$13,299

Job Description: Director, Population Health Division and PS 18-1802 Principal Investigator (T. Aragon) This position is in-kind. Dr. Aragón is the San Francisco Health Officer and the Director of the Population Health Division (PHD) of SFDPH. Dr. Tomas Aragón provides overall leadership of the project. Dr. Aragón is responsible for overall planning, implementation, monitoring, and reporting of the program. Dr. Aragon also provides oversight for the Continuous Quality Improvement (CQI) and evaluation activities.

Job Description: Deputy Director, Population Health Division (C. Siador) Ms. Siador is the Business Official for this cooperative agreement. This position is in-kind. She has overall budget/grant oversight authority, and works closely with Finance, Budget and Contracts departments to oversee that grant deliverables are met by established deadlines. As one of the project sponsors, she will provide guidance and input as needed.

Job Description: Director, Disease Control and Prevention Branch and Project Co-Director (S. Philip) – This position is in-kind. Dr. Philip is a Project Co-Director for both Component A and Component B, the OPT-IN Demonstration Project, and is responsible for overseeing the disease control and prevention arm of both components. Dr. Philip works closely with other co-directors and project leads to monitor all short-term outcomes and maintain smooth implementation of all project strategies. This position shares the lead role in the CQI activities and is responsible for tracking and reporting all activities to CDC annually.

Job Description: Manager II – (T. Packer)
This position is the Director of the Community Health Equity and Promotion Branch (CHEP) which houses San Francisco's community-based HIV programs that are funded to end new HIV infections and ensure that HIV-infected persons are linked to care and treatment, in collaboration with the branch's STD and HCV prevention programs. In collaboration with Susan Scheer, Susan Philip, and the CHEP staff, and under the direction of Dr. Tomas Aragon, Principal Investigator, the Director is responsible for ensuring the SFDPH outcomes for Component A (and Component B if funded) are achieved. The Director ensures collaboration across the HIV prevention and care network in San Francisco and supports programs to work collaboratively to ensure effective, sustainable, high impact, cost-efficient programs that decrease HIV incidence

and improve health equity. The Director oversees multiple HIV, STD, and HCV prevention interventions throughout SF funded with CDC funds, City General Funds, and a California State funds. The Director oversees the work of CHEP to inform policies, laws, and other structural factors that influence HIV prevention and treatment, emphasizing the need to address an individual's overall health as part of HIV prevention efforts. The Director also oversees a team of staff members that serve as the primary contact for community-based providers. The Director works closely with the HIV Community Planning Council (HCPC) and sits on the steering committee for the Getting to Zero Initiative, is a member of UCHAPS and NASTAD, and works closely with the California State Office of AIDS.

Job Description: Health Program Coordinator III – (J. Melichar)
This position acts as the Community-Based HIV Prevention Services Coordinator. Oversees all community-based program liaison activities for the CHEP branch. He manages staff that work directly with community-based organizations and other providers to support the implementation and evaluation of programs to meet the goals and objectives of the HIV prevention strategy. The position manages staff that provide technical assistance and training to contractors to build capacity and ensure deliverables are met in HIV testing, prevention with negatives and positives, condom distribution, and policy initiatives. Oversees budget management for community-based organizations. Primary liaison to the Contract Development and Technical Assistance Section, the Business Office of Contract Compliance, the Contracts Unit and all fiscal offices. Acts as primary liaison to the data management branch, ARCHES. EvalWeb, and CDC liaison.

Job Description: Senior Health Educator – (D. Geckeler)
This position acts as the Quality Improvement and Evaluation Coordinator for CHEP and oversees HIV, HCV, and STD program integration within San Francisco's system of HIV prevention. Using the results based accountability approach, this position works with SFDPH staff and partners, including community-based organizations, to determine expected outcomes and specific program performance measures. This approach will be used for both Component A and Component B if funded. The Senior Health Educator uses Results Scorecard for the Getting to Zero Initiative. RSC tracks the performance of program and measures the impact of funding and achievement of outcomes. This position oversees the SFDPH team that works with CBOs and monitors outcomes.

Job Description: Health Program Coordinator III – (J. McCright)
This position serves as one of the Deputy Directors of the CHEP branch and oversees HIV and STD prevention staff and integration of HIV, STD, and HCV prevention activities in community-based testing for gay men and other MSM. The Deputy Director supervises staff that perform HIV testing and outreach in the community as well as staff that implement environmental prevention in sex clubs, massage parlors, and other commercial sites where sex among men may occur.

Job Description: Health Educator – (N. Underwood)
This position serves on the quality improvement team for CHEP and is responsible for developing and monitoring performance measures for HIV prevention programs funded through CHEP. The position ensures that the goals and objectives of HIV-related grants within SFDPH grants are being met. In addition, this position is a liaison to the HCPC. This position will ensure that the new testing strategy is implemented through providing training to HIV test counselors and technical assistance to HIV test providers.

Job Description: Health Program Coordinator II – (T. Knoble)
The Program Coordinator II provides individual training, technical assistance, and quality assurance oversight to HIV testing sites and other prevention programs, meeting with them regularly as well as providing group California State Certification training. He develops implements and evaluates the training for HIV test counselor certification. Works with the State Office of AIDS to ensure testing training meets State standards. Ensures that most recent testing technologies are implemented with approval from the State and CDC.

Job Description: Health Program Coordinator I – (Vacant)
This position acts as government co-chair to the HCPC and supports development and implementation of HIV testing strategies in community-based settings and substance use treatment sites. Trains HIV test counselors to ensure the SF HIV strategy is implemented. The position provides direction to substance use organizations on implementation of HIV testing programs and participates in the drug user health initiative an internal planning body to SFDPH.

Job Description: Health Program Coordinator I – (T. Ick)
This position supports development and implementation of HIV testing strategies in community-based settings. Trains HIV test counselors to ensure the SF HIV strategy is implemented. Provides technical assistance on CLIA procedures. The position provides direction to substance use organizations on implementation of HIV testing programs.

Job Description: Health Worker II (TBD)
The position is a community liaison who ensures that works with community members and bodies to meet the goals and objectives of HIV-related grants within SFDPH. This position oversees community engagement programs with focus populations, especially communities with HIV health disparities.

Job Description: Health Worker II (TBD)
The position is a community liaison who ensures that works with community members and bodies to meet the goals and objectives of HIV-related grants within SFDPH. This position oversees community engagement programs with focus populations, especially communities with HIV health disparities

Job Description: Management Assistant – (B. Chan Lew)

This position supports the HCPC and staff through the development and implementation of communication systems for coordination of HCPC activities. This position manages the condom distribution program that ensures condoms are accessible throughout the City and County through venues accessible to high prevalence populations. Condoms are provided to venues such as commercial venues, community-based organizations, and convenience stores.

Job Description: Health Program Coordinator II – (B. Ivory)
This position is responsible for implementation of community-based HIV, STD, and HCV testing in community settings such as gyms, clubs, and other venues where gay men and other MSM gather. He oversees training, operations, and evaluation of the program. He provides support to initiatives for high prevalence populations, especially those programs reaching African American gay men and other MSM.

Job Description: Health Educator – (H. Hjord)
This position is responsible for integrating behavioral health interventions into HIV prevention and care programs throughout the system of care. Works closely with community- based HIV prevention programs, clinical prevention, and policy areas to integrate with behavioral health. She oversees the intersection of alcohol programs and HIV prevention programs and oversees the SFDPH strategic plan for addressing alcohol. If SF is funded for Component B, this position will project manage the entire Project OPT. She will convene the leadership, the staff, and all partners working on the project to monitor performance measures and achieve outcomes.

Job Description: Health Worker III (TBD)
The position is a community liaison who oversees the work with community members and bodies to meet the goals and objectives of HIV-related grants within SFDPH. This position oversees community engagement programs with focus populations, especially communities with HIV health disparities. This position will engage with community members in community settings to educate and link to services.

Job Description: Epidemiologist II – (J. Chin)
The Epidemiologist ensures that HIV testing and Risk Reduction Activities data are collected and submitted by internal and external programs, cleaned, stored and prepared for reports on a timely basis. The Epidemiologist manages Evaluation Web data and reports and is responsible for providing technical assistance for community-based staff collecting and entering testing data. The position interfaces with CDC and contractors to submit data and trouble shoots data problems.

Job Description: Health Program coordinator I - (Oscar Macias)
This position is responsible for participating in community STD/HIV outreach activities; collecting STD specimens and providing HIV testing; providing HIV/STD health education. The health worker identifies appropriate venues and schedule and oversees community-based STD and HIV activities; set up testing facilities at each community site;

resolve problems at community events; order testing supplies, informational handouts, and safer sex materials; conduct street/venue-based assessments for syphilis awareness social marketing campaign; collect data and compile reports; and train new field specialist staff.

Job Description: Health Educator – (Michael Paquette)
This position works as part of the planning team to ensure the HIV Community Planning Council (HCPC) meets the grant requirements and local planning needs. He also coordinates data and qualitative reporting to meet grantor requirements and provides administrative and coordinating support for HIV/HCV testing counseling training efforts.

Job Description: Principal Administrative Analyst (TBD)
This position oversees the system for grant management for the division and will be responsible for quality management of contract documents. This position will also coordinate the contract development process, study, recommend, and implement system changes and provide technical assistance process. This position will train new program managers and program liaisons on issues related to contract work.

B. FRINGE BENFITS @ 45% $498,059

C. CONSULTANT COSTS $0

D. EQUIPMENT $0

E. MATERIALS AND SUPPLIES $17,000

Item Requested	Type	Number Needed	Unit Cost	Amount Requested
Office Supplies	Paper pens, handouts	12 mos	$18.18/month X 11 FTE	$2,400
Condoms	n/a	132,727	Approximately 132,727 condoms at $.11 each	$14,600

Office Supplies: This line item includes general office supplies required for daily work for programmatic staff, as well as supplies for meetings conducted by the program. These include, but are not limited to paper, pens and handouts.

Condoms: Approximately 1,268,445 condoms and lube at approximately $.11 each.

F. TRAVEL $12,784

Item		Rate	Cost
Local Travel	Muni Passes and Tokens	2 passes x $66/pass x 12 months and 5 bags of tokens x $20/bag x 12 months	$2,784
Out-of-State Travel	Airfare	Round Trip @ $700 x 4 staffs x 1 trip	$2,800
	Lodging	$222.5 per night x 4 nights x 4 staffs	$3,560
	Per diem	$70 per day x 4 days x 4 staffs x 1 trip	$1,120
	Transportation	$130/staff x 4 staffs x 1 trip	$520
	Registration	$500/staff x 4 staffs x 1 trip	$2,000

Local Travel: Muni passes are used for staff travel to meetings within San Francisco with contractors, HPPC members, and community members. Tokens are provided to clients as necessary for transportation to appointments when linking to care.

Out-of-State Travel: Travel budgeted for one CDC meeting for four staff members or UCHAP meeting.

Itinerary

G. OTHER **$43,000**

Item	Rate	Cost
Office Rent	$1.93/sq ft x 250sq. ft. x 12 months x 7.43 FTE	$43,000

Office Rent: Office rent covers expenses of office space rentals and maintenance for the HPS staff to perform their duties.

H. CONTRACTUAL **$2,244,738**

Contractor	Total Cost
Public Health Foundation Enterprises	$787,490
San Francisco Department of Public Health Disease Prevention and Control (SFDPH STD)	$955,748
San Francisco Department of Public Health Lab	$448,000
Glide	$37,500
BAART	$2,000
Bayview Hunter Point Foundation	$2,000
HealthRight360	$2,000
Resource Development Associates	$2,000
San Francisco AIDS Foundation	$4,000

UCSF	$2,000
Westside	$2,000

1. **Name of Contractor: Public Health Foundation Enterprises, Inc. (PHFE, DBA Heluna Health)**

Method of Selection: Request for Qualifications (RFQ) RFQ36-2017
Period of Performance: 01/01/2019 - 12/31/2019
Scope of work

i) Service category: Fiscal Intermediary
   (1) Award amount: $787,490
   (2) Subcontractor: None
ii) Services provided: Fiscal intermediary services to the SFDPH HPS. PHFE pays for four staff members and travel that support the goals and objectives of Category A. The staff supports community-based prevention efforts through operations training and technical assistance, in addition to coordination of data systems, expanding and adapting partnerships and collaborations.

Method of Accountability: Annual program and fiscal and compliance monitoring

Itemized budget and justification:

A. Salaries $191,804

Position Title and Name	Annual	Time	Months	Amount Requested
Front Desk Associate T. Loftin	$47,143	45%	12 months	$20,701
Executive Assistant M. Varisto	$64,012	90%	12 months	$59,319
Finance & Operation Manager A. Sogal	$107,598	40%	12 months	$44,330
Assistant Administrator M. Martin	$60,599	30%	12 months	$19,601
Program Assistant D. Ball	$47,853	100%	12 months	$47,853

Job Description: Front Desk Associate – (T. Loftin)
The Front Desk Associate provides oversight of the reception area, answering a multi-line telephone and directing calls, guests, staff, messenger services and deliveries from various vendors and community-based organizations and other community representatives.

Job Description: Executive Assistant – (M. Varisto)

The Executive Assistant provides ongoing support for the project, including coordination of meetings and on-going conference calls between all parties involved. She also assists with preparing project presentation and editing reporting documents. She works with the Finance and Operations Manager in managing project expenses.

Job Description: Finance and Operations Manager – (A. Sogal)
The Finance and Operations Manager is responsible for the fiscal management, policy development, and financial reporting of projects related to the SFDPH HPS CHEP. She develops budgets, monitors grants, and establishes contracts, sub-contracts, and cooperative agreements in addition to managing FTEs, benefits, budget estimates, and monthly reports to assist with the execution of activities. These reports are also used to make staffing, space and other logistically based decisions to ensure capacity, and to meet section needs. The Finance and Operations Manager collaborates with PHFE and SFDPH (Accounts Payable, Payroll, Human Resources, and Fiscal) on a regular basis to facilitate project activities.

Job Description: Assistant Administrator – (M. Martin)
The Assistant Administrator assists in the financial reporting, contract and grant management. She assists with process and reconciliation of expenditures, as well as in the execution of contracts and purchasing. She is responsible for managing tasks associated with accounts payable, payroll.

Job Description: Program Assistant (D. Ball)
The position will schedule internal meetings, organize training and other logistics, submit travel requests and reimbursements, and assist program staff for both programmatic activities as needed.

B. Fringe Benefits @ 37.18% total salaries $71,313

C. Consultant Costs $0

D. Equipment $0

E. Materials and Supplies $341,311

Item	Type	Number Needed	Unit Cost	Amount Requested
Office supplies	Paper pens, handouts	12 mos	$300/month x 12 months	$3,600
IT Supplies	CPU	4	$2,000 each x 4 computers	$8,000

Program Supplies	n/a	12 mos	$2,317.50/month x12 months	$27,810
Lab Supplies	n/a	12 mos	$2,808.42/month x 12 months	$33,701
HCV Test	n/a		$18/test x 600 test =$10,800 $35/control x 40 controls =$1,400	$12,200
HIV Tests	n/a		$10/test x 2,083tests/month x 12 months=$250,000 $30/control x 200 controls/year = $6,000	$256,000
Total				$341,311

Office Supplies: General office supplies required for daily work for PHFE staff including, but not limited to pens, paper.

IT Supplies: Including but not limited to 8 desktop computers including all appropriate software.

Program Supplies: Funds will be used to purchase program supplies including but not limited to condoms, non-monetary incentives and promotional incentives for outreach and supplies needed for implementation of forums and focus groups. Disposable phones and minutes are purchased to address safety issues for outreach workers. In addition, this line may include supplies required to for council and community meetings, costs include materials and light refreshments. Refreshments are provided as incentives and support to community members living with HIV. Providing refreshments assists those who take medication to stay for the duration of the meeting.

Lab supplies: Additional supplies to perform HIV testing including but not limited to swabs, gauze, bandages.

HCV test kits: Funds for the purchase of approximately 600 test kits and 40 controls.

HIV test kits: Funds for the purchase of approximately 25,000 test kits and 200 controls.

F. Travel $18,827

Item		Rate	Cost
Local Travel	Mileage	50 miles/month x $0.565/mile x 12 months x 5 staff = $1,695	$3,195
	Parking	$5/month x 12 months x 5 staff = $300	
	Muni Cards	$25/month x 12 months x 4 staff= $1,200	

Out-of-State Travel	Airfare	Round Trip @ $706 x 4 staff x 2 trips	$5,648
	Lodging	$173 per night x 2 nights x 4 staff x 2 trips	$2,768
	Per diem	$70 per day x 2 days x 4 staff x 2 trips	$1,120
	Transportation	$131/staff x 4 staff x 4 trips	$2,096
	Registration	$500/staff x 4 staff x 2 trip	$4,000
Total			$18,827

Local Travel: Muni passes are used for staff travel to meetings within San Francisco with contractors, HPPC members, and community members and other key stakeholders.

Out-of-State Travel: Travel budgeted for 2 CDC meeting for four staff member.

G. Other Expenses $76,736

Item	Rate	Cost
Training	$1000/staff development x 3 staff = $3,000	$3,000
Printing	$400/month x 12 months	$4,800
Shipping	$800/month x 12 months	$6,536
Telecommunications	$200/per month x 12 months	$2,400
Advertising/Outreach	$5,000/month x 12 months	$60,000
Total		$76,736

Training: Funds necessary to provide continuing medical education units, skills development and professional development courses and conference registration as well as phlebotomy training.

Printing: Funds for costs of printing outreach materials, promotional items and labeling giveaways to reach community members.

Shipping: Funds for shipping test specimens to public health lab from community agencies.

Telecommunication: Funds for programmatic conference calls with collaborators, community members and funders as well as cell phone and data charges for field staff.

Advertising/Outreach: Funds requested to pay for print advertising in publications for HIV/STD testing and prevention services, including but not limited to BAR and/or GLOSS magazine.

H. Contractual $0

Total Direct Costs	$699,991
Total Indirect Costs (@ 12.5% of Modified Total Direct Costs)	$87,499
Total Costs	$787,490

2. **Name of Contractor:** SFDPH, Disease Prevention and Control Branch, STD Prevention and Control Services
Method of Selection: Health Department Provided Service/Municipal STD Clinic
Period of performance: 01/01/2018 - 12/31/2018
Scope of work:
   i) Service category: Partner Services and Linkages for Community-Based Settings
      (1) Award amount: $955,748
      (2) Subcontractors: None
      (3) Services provided: Partner Services and Linkage.

   STD Prevention and Control staff for embedded partner services and linkages staff in the two primary HIV testing sites, San Francisco AIDS Foundation and UCSF Alliance Health Project, also funded on this application. Staff works on-site within the HIV testing program to provide immediate partner services and linkage to care for HIV positive clients.
   Method of Accountability: Annual program and fiscal and compliance monitoring

   Itemized budget and justification:

A. Salaries $591,644

Position Title and Name	Annual	Time	Months	Amount Requested
Health Worker III – Love	$65,702	100%	12 months	$65,702
Health Worker II - Reid	$56,758	100%	12 months	$56,758
Health Worker II - TBD	$56,758	100%	9 months	$42,569
Health Worker III – O'Neal	$63,017	100%	12 months	$63,017
Health Worker II – O'Hara	$59,726	100%	12 months	$59,726
Social Worker – A. Scheer	$86,762	5%	12 months	$4,338
Epidemiologist II – T. Nguyen	$105,742	30%	12 months	$31,723
Epidemiologist I – H. Brosnan	$68,146	44%	12 months	$29,983
IT Operations Support – Wang –L. Feng	$63,024	25%	12 months	$15,756
Physician Specialist – Darpun Sachdev	$187,000	75%	12 months	$140,250
Health Program Coordinator II – Erin Antunez	$81,822	100%	12 months	$81,822
Total				$591,644

Job Description: Health Worker III – Love
This position provides case management, partner services and linkages activities for new HIV cases, early syphilis cases that are co-infected with HIV and their partners from medical settings; provides HIV/STD prevention, risk reduction, risk assessment and disclosure counseling; makes and verifies completion of referrals; performs rapid HIV test and/or phlebotomy and performs field investigation and other follow up for HIV positive clients who do not return for their test results or who are infected with an STD and need treatment.

Job Description: Health Worker II – Reid
This position will provide case management, partner services and linkages activities for new HIV cases, early syphilis cases that are co-infected with HIV and their partners from medical settings, provide HIV/STD prevention, risk reduction, risk assessment and disclosure counseling; make and verify completion of referrals; perform rapid HIV tests and/or phlebotomy and perform field investigation and other follow up for HIV positive clients who do not return for their test results or who are infected with an STD and need treatment.

Job Description: Health Worker II – (TBD)
The Health Worker II is Linkage to Care/Partner Services Specialist. This position ensures that new HIV cases and early syphilis cases that are co-infected with HIV form medical settings receive partner services and linkage to care; provide case management and third party partner services for sex partners of HIV infected individuals; provides HIV/STD prevention counseling, risk reduction, risk assessment and disclosure counseling; make and verify completion for referrals; perform rapid HIV tests and/or phlebotomy and perform field investigation and other follow up for HIV positive clients who do not return for their test results or who are infected with an STD and need treatment.

Job Description: Health Worker III – O'Neil
This position works as part of the community planning team to ensure the HPPC meets the grant requirements and local planning needs. He will provide HIV and STD prevention outreach at community events and provides technical assistance and training for HIV prevention providers. This position will also work in the San Francisco City Clinic, the municipal STD clinic, to provide HIV/STD testing to clients seeking care.

Job Description: Health Worker III – O'Hara
This position will provide case management, partner services and linkages activities for new HIV cases, early syphilis cases that are co-infected with HIV and their partners from medical settings, provide HIV/STD prevention, risk reduction, risk assessment and disclosure counseling; make and verify completion of referrals; perform rapid HIV tests and/or phlebotomy and perform field investigation and other follow up for HIV positive

clients who do not return for their test results or who are infected with an STD and need treatment.

Job Description: Social Worker – A. Scheer
This position provides enhanced counseling and referrals for high risk negative clients and crisis intervention and referrals for active engagement and re-engagement in CARE for HIV positive clients identified through the third party partner notification program, counsels newly diagnosed HIV patients about the importance of partner services and assists with this activity as needed.

Job Description: Epidemiologist II – T. Nguyen
This position oversees all related surveillance activities; performs QA of data reported through the various surveillance streams; creates, implements, and oversees policy and protocol development for HIV activities; supervises data entry and other surveillance staff; identifies and problem solves parries to improving HIV surveillance; acts as back-up support for the integrated data-infrastructure of the program and liaises with partners on HIV/STD surveillance and program evaluation issues.

Job Description: Epidemiologist I – H. Brosnan
This position performs routine data QA and verification, cleaning, report generation and analysis; generates data set architectures and work with partners to ensure accurate and timely transfer of required data; assists in developing evaluations of epidemiologic data as they relate to HIV services offered and assist in analysis, presentation, and dissemination of results; and liaises with partners across programs to assist in policy development, planning and implementation.

Job Description: IT Operations Support – L. Feng
This position enters all required data into specified computerized databases, performs QA on the data and ensures that errors are identified and corrected, generates standardized statistical reports, updates data files and performs routine computer programming.

Job Description: Physician Specialist – D. Sachdev, MD
The Physician Specialist will oversee all aspects of the Expanded Testing Initiative, in addition to development and implementation of other HIV prevention initiatives in clinical settings such as navigation/retention interventions. The Physician Specialist will work with medical providers to support partner services and the SFDPH treatment guidelines. The Physician Specialist will focus on collaboration and coordination to integrate efforts into a seamless continuum of care. This position will report to the Director, Disease Prevention and Control and will supervise and provide back-up clinical support to the Navigation and Expanded Testing field staff. In addition to the responsibilities outlined above, the Physician Specialist will lead the Team efforts to analyze data, assess gaps in reporting capacity, identify barriers to reporting on reimbursement reporting and work with stakeholders to develop and implement

systems to better monitor billing processes to ensure that third-party payors are the payors of first resort. This position requires acknowledge of laboratory data systems, current billing protocols and ICD-10 codes and ability to negotiate with multiple SFDPH departments and University of California San Francisco Medical Center entities.

Job Description: Health Program Coordinator I – (Erin Antunez)
The SFDPH LINCS (Linkage, Integration, Navigation, and Comprehensive Services) Navigation Coordinator works under the supervision of the Director of Clinical Prevention and leads or assists in the development of the systems, policies and procedures, quality assurance (QA) measures, and training manuals needed for LINCS operations. This staff person directly oversees the HIV care navigator and is responsible for collecting data used to track client service utilization and monitor program outcomes. The coordinator also helps build and maintain the internal capacity to monitor and evaluate the outcomes of the LINCS Program.

B. Fringe Benefit @45%	$266,394
C. Consultant Costs	$0
D. Equipment	$0
E. Materials and Supplies	$97,710

Item	Type	Number Needed	Unit Cost	Amount Requested
Test Supplies	Test kits	8001	$12/test x 8001 tests	$96,014
STD Supplies	n/a		$141.35/month x 12 months	$1,696
Total				$97,710

Test Supplies: Funds are requested to purchase safer sex packets and STD test kits to use during outreach events where staff performs rectal, pharyngeal, and urine gonorrhea (GC) and Chlamydia (CT) testing and syphilis testing.

STD Supplies: Funds are requested to purchase supplies including condoms/lube and/or STD testing supplies for use with persons being tested for HIV at community screening events.

F. Travel	$0	
G. Other Expenses	$0	
H. Contractual		$0
Total Direct Costs SFDPH STD		$955,748
I. Indirect Costs SFDPH STD	$0	
Total Costs SFDPH STD		$955,748

3. **Name of Contractor:** SFDPH Public Health Lab
Method of Selection: Health Department Provided Service/Public Health Lab
Period of performance: 01/01/2018 - 12/31/2018
Scope of work
(1) Service category: HIV Testing: Laboratory Services
(1) Award amount: $448,000
(2) Subcontractors: none
(3) Services provided: Specimen Processing for HIV tests for Community-Based HIV Testing Partners
Method of Accountability: Annual program and fiscal and compliance monitoring

Itemized budget and justification:

A. Salaries: $194,400

Position Title and Name	Annual	Time	Months	Amount Requested
Senior Microbiologist - McQuaid	$114,110	100%	12 months	$114,110
Microbiologist - Tam	$90,800	25%	12 months	$22,700
Laboratory Technician II - Lew	$57,590	100%	12 months	$57,590

Job Description: Senior Microbiologist – McQuaid
The Sr. Microbiologist is responsible for overall supervision of the HIV testing section. The responsibilities include training of technical personnel, review of quality control records, and review of all results prior to reporting, preparing protocols, monitoring performance of the tests and assignment of responsibilities. Moreover, the Senior Microbiologist assembles, organizes and provides all data regarding HIV testing for the HPS at SFDPH.

Job Description: Microbiologist – O. Tam
The Microbiologist conducts HIV antibody test, including screening and confirmation tests. The responsibilities include performing screening (EIA and CMMIA) and supplemental testing IFA and WB) on blood-based and oral fluid specimens, validating and reporting test results and performing quality control procedures. The Microbiologist also performs RNA testing on pooled specimens and tests individual specimens for RNA when required.

Job Description: Laboratory Technician II – A. Lew
The Laboratory Technician processes and prepares specimens for HIV-1 antibody testing for the HIV Testing program. The Lab Technician also prepares the pooled specimens

tested or HIV RNA. The principal duties include logging-in and labeling specimens, validating specimens requisition/report forms, separation of serum by centrifugation of pipetting oral fluids and preparation of worksheets and reagents. This position also daily monitors laboratory equipment such as refrigerators and centrifuges for quality assurance purposes.

B. Fringe Benefits @ 46% $89,424
C. Consultant Expenses $0
D. Equipment: $0
E. Materials and Supplies: $139,176

Item Requested	Type	Number Needed	Unit Cost	Amount Requested
Test Kits (HIV and RNA)	HIV Tests	7032	$7.10/ test x 7,032 HIV tests	$49,928
	RNA Tests	1810	$46.00 x 1,810 RNA tests	$83,260
Specimen Database Maintenance	n/a		$499/month x 12 months	$5,988
Total				$139,176

Test Kits – funds for the purchasing of HIV EIA, CMMIA, IFA test kits.
Monthly contract maintenance for MLAB, the laboratory's Information Management System (LIS) and other preventive maintenance service for instruments in the Public Health Laboratory.

Specimen Database Maintenance – Funds will be used to cover regular maintenance of specimen database.

F. Travel $0
G. Other Expenses $25,000

Item	Description	Cost
Rental of Equipment	$1,666.67/month x 12 months	$20,000
Message/Courier Services	Approx. $416.67/month x 12 months	$5,000
Total		$25,000

Rental Equipment – Rental costs for MLAB, the laboratory information management system (LIS) and other preventive maintenance service for instruments in the Public Health laboratory.

Shipping/Delivery – Funds for message services for daily delivery of blood specimens to the Public Health Laboratory.

H. Contractual	$0
Direct Costs	$448,000
I. Indirect Costs	$0
Total Costs	$448,000

5.Name of Contractor: GLIDE Foundation
Method of Selection: Request for Proposals (RFP) RFP30-2015
Period of performance: 01/01/2019 - 12/31/2019
Scope of work

(1) Service category: HIV Testing: Laboratory Services
(2) Award amount: $37,500
(3) Subcontractors: none
(4) Services provided: Staff will engage in harm reduction and linkage to care/outreach in the community, street based, SRO Hotels, Methadone Programs, city shelters, and treatment programs, will be part of our recruitment outreach.

Method of Accountability: Annual program and fiscal and compliance monitoring

Itemized budget and justification: Total Budget $37,500. Itemized justification will be provided once contract negotiated to CDC.

6. Name of Contractor: BAART Community Health Care
Method of Selection: Admin Code 21.42 (Sole Source)
Period of performance: 01/01/2019 - 12/31/2019
Scope of work

(1) Service category: HIV Testing - Infectious Disease Testing for Drug Users
(2) Award amount: $2,000
(3) Subcontractors: none
(4) Services provided: The BAART Program provides HIV and HCV testing in a medication-based opioid treatment setting that provides a comprehensive continuum of care and treatment for substance users including methadone and buprenorphine detoxification and maintenance, addiction and relapse prevention education, case management and integrated primary health care.

Method of Accountability: Annual program and fiscal and compliance monitoring

Itemized budget and justification: Total Budget $2,000. Itemized justification will be provided once contract negotiated to CDC.

7. Name of Contractor: BayView Hunters Point Foundation
Method of Selection: Admin Code 21.42 (Sole Source)
Period of performance: 01/01/2019 - 12/31/2019
Scope of work

(1) Service category: HIV Testing in Methadone Program
(2) Award amount: $2,000
(3) Subcontractors: none
(4) Services provided: Bayview Hunters Point Foundation provides HIV and HCV testing in a community-based medication-based opioid treatment setting for substance users including both methadone and buprenorphine detoxification and maintenance, addiction and relapse prevention education, case management and integrated primary health care.

Method of Accountability: Annual program and fiscal and compliance monitoring

Itemized budget and justification: Total Budget $2,000. Itemized justification will be provided once contract negotiated to CDC.

8. Name of Contractor: HealthRight360
Period of performance: 01/01/2019 - 12/31/2019
Scope of work:

(1) Service category: HCV Linkages to Care services
(2) Award amount: $2,000
(3) Subcontractors: none
(4) Services provided: Through its Integrated Prevention Program, HR360 improves patient access to services and early detection of infectious diseases, through HIV/HCV screening and testing funded under this grant.

Method of Accountability: Annual program and fiscal and compliance monitoring

Itemized budget and justification: Total Budget $2,000. Itemized justification will be provided once contract negotiated to CDC.

9. Name of Contractor: Resource Development Associates
Method of Selection: Request for Qualifications (RFQ) RFQ36-2017
Period of performance: 01/01/2019 - 12/31/2019
Scope of work:

(1) Service category: Admin Capacity Building
(2) Award amount: $2,000
(3) Subcontractors: none

(4) Services provided: Facilitate 5 town hall meetings, share previous focus group findings and get community ideas for SDDT uses. Assist in creating a 3 year strategic plan.

Method of Accountability: Annual program and fiscal and compliance monitoring

Itemized budget and justification: Total Budget $2,000. Itemized justification will be provided once contract negotiated to CDC.

10. Name of Contractor: San Francisco AIDS Foundation
Method of Selection: Admin Code 21.42 (Sole Source)
Period of performance: 01/01/2019 - 12/31/2019
Scope of work

(1) Service category: HIV Testing - Infectious Disease Testing for Drug Users & Syringe Cleanup
(2) Award amount: $4,000
(3) Subcontractors: none
(4) Services provided: SFAF provides HIV/HCV screening and testing to MSM in a substance use treatment program, self-help recovery, syringe programs and other recovery programs primarily at the 6th Street Harm Reduction Center.

Method of Accountability: Annual program and fiscal and compliance monitoring

Itemized budget and justification: Total Budget $2,000. Itemized justification will be provided once contract negotiated to CDC.

11. Name of Contractor: University of California at San Francisco (UCSF)
Method of Selection: Admin Code 21.42 (Sole Source)
Period of performance: 01/01/2019 - 12/31/2019
Scope of work

(1) Service category: HIV Testing in Methadone Program
(2) Award amount: $2,000
(3) Subcontractors: none
(4) Services provided: Staff will perform HIV/HCV/STD counseling and testing as well as directly observed therapy for HIV medication dispensation in the Opiate Treatment Outpatient Program at Zuckerberg San Francisco General Hospital.

Method of Accountability: Annual program and fiscal and compliance monitoring

Itemized budget and justification: Total Budget $2,000. Itemized justification will be

provided once contract negotiated to CDC.

12. Name of Contractor: Westside Community Health Center
Method of Selection: Admin Code 21.42 (Sole Source)
Period of performance: 01/01/2019 - 12/31/2019
Scope of work

(1) Service category: HIV Testing in Community Health Center
(2) Award amount: $2,000
(3) Subcontractors: none
(4) Services provided: Westside provides HIV testing services to clients engaged in substance abuse treatment, prevention services or accessing services at Maxine Hall Clinic. Through Opt-Out testing, the program is able to provide routine HIV testing for everyone -meaning that HIV tests will be done routinely unless a patient explicitly refuses to take an HIV test.

Method of Accountability: Annual program and fiscal and compliance monitoring

Itemized budget and justification: Total Budget $2,000. Itemized justification will be provided once contract negotiated to CDC.

	TOTAL DIRECT COSTS:	**$3,922,382**
I.	**INDIRECT COSTS** (25% of total salaries)	$276,700
	TOTAL BUDGET:	**$4,199,083**

San Francisco Department of Public Health, SF Division
Applied Research, Community Health Epidemiology, and Surveillance Branch
PS18-1802 Integrated HIV Surveillance and Prevention Programs for Health Depts.
Component A HIV Surveillance Budget
01/01/2019-12/31/2019

A. Personnel	$389,694
B. Mandatory Fringe	$163,672
C. Consultant Costs	$0
D. Equipment	$0
E. Materials and Supplies	$1,681
F. Travel	$13,226
G. Other Expenses	$26,197
H. Contractual	$117,401
TOTAL DIRECT COSTS	**$711,871**
I. Indirect Costs (25% of total salaries)	$97,424
TOTAL BUDGET	**$809,294**

A. SALARIES $389,694

Position Title and Name	Annual	FTE	Months	Amount Requested
Director, Population Health Division, and Principal Investigator (PI) T. Aragon, MD, DrPH	NA		12	In-Kind
Deputy Director, Population Health Division C. Siador, MPH	NA		12	In-Kind
Director, Disease Prevention and Control S. Philip, MD, MPH	NA		12	In-Kind
Director, Applied Research, Community Health Epidemiology, & Surveillance (ARCHES) W. Enanoria, MPH, PhD	N/A		12	In-Kind
Director, HIV Epidemiology ARCHES/Manager II S. Scheer, PhD, MPH	$142,766	50%	12	$71,383
Director of HIV Case Surveillance/Manager I L. Hsu	$132,990	100%	12	$132,990
HIV Surveillance Coordinator/Health Program Coordinator III M.K. Parisi	$115,778	50%	12	$57,889
Epidemiologist II S. Pipkin	$60,783	50%	12	$30,392
Health Program coordinator II V. Delgado	$101,946	50%	12	$50,973
Epidemiologist I E. Mara	$82,264	56%	12	$46,068

Job Description: Director, Population Health Division and PS 18-1802 Principal Investigator (T. Aragon) This position is in-kind. Dr. Aragón is the San Francisco Health Officer and the Director of the Population Health Division (PHD) of SFDPH. Dr. Tomas Aragón provides overall leadership of the project. Dr. Aragón is responsible for overall planning, implementation, monitoring, and reporting of the program. Dr. Aragon also provides oversight for the Continuous Quality Improvement (CQI) and evaluation activities.

Job Description: Deputy Director, Population Health Division (C. Siador) Ms. Siador is the Business Official for this cooperative agreement. This position is in-kind. She has

overall budget/grant oversight authority, and works closely with Finance, Budget and Contracts departments to oversee that grant deliverables are met by established deadlines. As one of the project sponsors, she will provide guidance and input as needed.

Job Description: Director, Disease Control and Prevention Branch and Project Co-Director (S. Philip) – This position is in-kind. Dr. Philip is a Project Co-Director for both Component A and Component B, the OPT-IN Demonstration Project, and is responsible for overseeing the disease control and prevention arm of both components. Dr. Philip works closely with other co-directors and project leads to monitor all short-term outcomes and maintain smooth implementation of all project strategies. This position shares the lead role in the CQI activities and is responsible for tracking and reporting all activities to CDC annually.

Job Description: Wayne Enanoria, PhD, MPH is the ARCHES Branch Director, Associate Chief Health Informatics Officer for Population Health Division, Assistant Adjunct Professor of Epidemiology in the Division of Infectious Disease Epidemiology, and a faculty affiliate of Global Health Sciences at UCSF. His previous work experience includes applied public health as a communicable disease epidemiologist (all levels) for local and state health departments in the areas of HIV, vaccine-preventable diseases, public health preparedness & emergency response, as well as academic work at UC Berkeley and UCSF. For this cooperative agreement, he brings his research and professional experiences in population health, the control and prevention of communicable diseases, public health informatics, infectious disease epidemiology, and systems science. He will provide in-kind support to the HIV surveillance and prevention activities.

Job Description: As the Director of the HIV Epidemiology Section for the Applied Research, Community Health Epidemiology and Surveillance Branch (S.Scheer), principal duties include planning, developing, coordinating, directing and evaluating all scientific aspects of HIV/AIDS surveillance and epidemiological studies. She is responsible for overseeing data collection and analysis, interpreting, writing and disseminating findings. She will serve as the Co-Director of the CDC PS18-1802 NOFO and will be responsible for assuring that surveillance activities and data are fully integrated with program goals and activities and are used to evaluate programs and identify areas for improvement. She will serve as the primary representative for SFDPH on HIV surveillance activities and attend all CDC program meetings as the SFDPH surveillance representative. She will supervise four senior epidemiologists.

Job Description: Director of HIV Case Surveillance (L. Hsu) Principal duties include directing and coordinating HIV/AIDS surveillance and reporting activities, conducting epidemiological studies and statistical analyses related to the HIV and AIDS registry. She oversees data collection, management, analysis, and use of the data for HIV/AIDS surveillance. She is responsible for developing methods for conducting retrospective and prospective medical chart reviews, developing methods and logistics to evaluate

HIV/AIDS surveillance and reporting activities, analyzing, evaluating, and interpreting statistical data in preparing HIV/AIDS reports, responding to surveillance data requests and disseminating HIV/AIDS epidemiological data through presentations and publications, preparing annual progress reports, and developing grant proposals. She supervises the performance of one Health Program Coordinator II, three Epidemiologist II and one Epidemiologist I. She is the primary contact person with the CDC and the State regarding HIV/AIDS surveillance/reporting issues.

Job Description: HIV Surveillance Coordinator (M.K. Parisi) Principal duties include managing and supervising daily activities of HIV surveillance program, assisting in the planning, developing, coordinating, and monitoring of HIV/AIDS surveillance and related projects, coordinating progress reports, grant proposals, contracts and MOUs. She is responsible for coordinating recruitment, hiring, and training of staff, developing policies and procedures. She is responsible for attending a minimum of four community planning group meetings. She serves as the lead liaison between the surveillance program and our active surveillance sites for case reporting activities. She is responsible for establishing and maintaining active and passive HIV/AIDS surveillance at designated sites. She contacts medical providers and laboratory personnel to update reporting requirements, answers questions from the public and responds to HIV/AIDS statistical data, and gives public presentations on topics related to HIV/AIDS surveillance. She supervises three Research Associate and one Administrative Assistant.

Job Description: (S. Pipkin) Principal duties include assisting the State Office of AIDS in the development of standards and protocols for eHARS data transfer, quality assurance, case merging, duplicate management, and out of jurisdiction and out of state HIV/AIDS cases. She will serve as the key contact person to the State Office of AIDS for eHARS. She is responsible for analyzing HIV/AIDS surveillance data, preparing technical and scientific reports, responding to surveillance data requests, developing computer programs and procedures for conducting matches with other databases or registries, processing electronic laboratory reports, and developing methods to evaluate the HIV/AIDS surveillance system. She has direct supervision of four staff members: two epidemiologists, and two data entry IS operators.

Job Description: (V. Delgado) Principal duties include coordinating surveillance activities, establishing and maintaining active HIV/AIDS surveillance at local medical facilities, performing field staff data collection quality assurance including review of completed case report forms and prospective and retrospective chart review forms, and conducting validity evaluation by re-abstracting case information on 10% of previously reported cases. She coordinates data sharing activities with SFDPH's partner services and linkage to care program. She conducts RIDR, resolves duplicated case reports with other jurisdictions and obtains updated information for our cases. She is responsible for ensuring that protocols for conducting surveillance field activities as well as security and confidentiality procedures are adhered to. She supervises one Health Program Coordinator I and indirectly supervises four field staff.

Job Description: (E. Mara) Funds will be used to support an Epidemiologist to conduct and coordinate activities related to enhancing laboratory reporting. Tasks include evaluating current laboratory reporting system and practice, contacting laboratories and working with the State Office of AIDS for electronic reporting and data standardization and quality issues, developing computer programs and standard operating procedures for laboratory data processing and management, coordinating development of laboratory data management system, and conducting analyses using CD4 and viral load data.

B. MANDATORY FRINGE @ 42% $163,672
C. CONSULTANT COSTS $0
D. EQUPMENT $0
E. MATERIALS AND SUPPLIES $1,681

Item Requested	Type	Number Needed	Unit Cost	Amount Requested
Office Supplies	Paper, Pens, binders, presentation materials, folders	12 mos	$140.08/month x 12 months	$1,681

Office supplies: Funds will cover the cost of basic office supplies for staff including but not limited to computers, software, pens, paper, folders, binders, presentation materials and other items used on a daily basis.

F. TRAVEL $13,226

Travel		Rate	Quantity	Cost
Local Travel	Muni Pass	$66.90/mo.	x 12 mo. x 10 staff	$8,026
CDC Annual Meeting	Airfare	$500/traveler	x 4 travelers = 2,000	$5,200
	Lodging	$200 per night x 4 nights	x 4 travelers = 3,200	

Local Travel: To purchase bus passes to travel to sites to conduct surveillance activities and field investigations for Surveillance staff.

CDC Meetings: Funds to cover costs of domestic travel to Atlanta, GA for CDC meetings for 4 staff.

G. OTHER $26,197

Item	Rate	Cost
Office Rent	$1.93/sq.ft./month x 250 sq. ft. x 12 months X 4.53 FTE	$26,197

Office Rent: Funds to cover expenses of space rentals and maintenance for the Surveillance staff and security for HIV/AIDS registry for compliance with CDC requirements and mandates.

H. CONTRACTUAL **$117,401**

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

   Method of Selection: Request for Qualifications (RFQ) RFQ36-2017

   Period of performance: 1/1/2019 – 12/31/2019

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

   Description of activities: PHFE will provide the staffing for the development of databases, data management and analysis, maintenance and technical services for computer equipment, and for conducting surveillance field activities including reviewing medical records and collecting case report information. They have demonstrated expertise in this area and have an established relationship with the SFDPH.

   Itemized budget with narrative justification:

   a. Salaries $68,288

Position Title and Name	Annual	Time	Months	Amount Requested
Research Associate Q. Martin	$51,605	50%	12	$26,383
Front Desk Associate T. Loftin	$47,143	24%	12	$11,501
Assistant Administrator M. Martin	$60,599	5%	12	$3,323
Finance & Operation Manager A. Sogal	$107,598	5%	12	$5,541
Administrative Assistant (A. Flandez)	$70,221	30%	12	$21,540

   Job Description: (Q. Martin) Research Associate principal duties include establishing and maintaining active HIV/AIDS surveillance at local medical facilities, consisting of multiple weekly field visits to identify HIV/AIDS cases by

contacting the infection control practitioner and reviewing admissions logs, laboratory ledgers and medical records; responsible for conducting health status updates, retrospective and prospective chart reviews on HIV/AIDS cases including updating contact information for Data-to-Care activities.

Job Description: (T. Loftin) The Front Desk Associate will provide oversight of the reception area, answering a multi-line telephone and directing calls, guests, staff, messenger services and deliveries from various vendors.

Job Description: (M. Martin) The Assistant Administrator is responsible for processing invoices and expenses associated with accomplishing program activities. She reports to the Finance and Operations Manager and is responsible for all paperwork associated with accounts payable, payroll, human resources, and fiscal. In addition, she manages deadlines and ensures all CDC reporting requirements are met.

Job Description: (A. Sogal) The Finance and Operations Manager is responsible for the fiscal management, policy development, financial reporting, and program evaluation of surveillance and research projects related to the HIV surveillance program. She develops budgets, monitors grants, and establishes contracts, sub-contracts, and cooperative agreements in addition to managing FTEs, benefits, budget estimates, and monthly reports to assist with the execution of activities. These reports are also used to make staffing, space and other logistically based decisions to ensure capacity, and to meet program needs. The Research Administrator will collaborate with PHFE and the SFDPH (Accounts Payable, Payroll, Human Resources, and Fiscal) on a regular basis to facilitate program activities.

Job Description: (A. Flandez) This position provides clerical support for the HIV surveillance program. Duties include typing, telephone contact, scheduling, taking minutes, developing memos and other communications, computer entry, and other secretarial duties.

b. Mandatory Fringe @ 36.87%	$25,178
c. Consultant Costs	$0
d. Equipment	$0
e. Materials and Supplies	$7,600

Item Requested	Type	Number Needed	Unit cost	Amount Requested
Program Supplies	Binders, folders, paper, pen	12 mos	$300/month x 12 months	$3,600
IT Supplies	CPU+ software	2	$1500/computer + $500/software x 2	$4,000

Program Supplies: Funds will cover the cost of general programmatic supplies including but not limited to purchase general office supplies such as binders, folders, etc.

IT Supplies: Funds will cover the cost of purchasing/upgrading computers and software for programmatic staff.

f. Travel Costs $840

Travel	Rate	Quantity	Cost
Local Travel	$70/mo. bus pass	x 12 month	$840

Local Travel: To purchase bus passes for contract employees to travel to sites to conduct surveillance activities and field investigations.

g. Other Costs $2,477

Other Costs	Rate	Quantity	Cost
Training	$1,238.50/staff	X 2 staff	$2,477

Training Costs: Funds will be used to pay for ongoing training for staff.

h. Contractual	$0
Total Direct Costs	$104,383
i. Total Indirect (12.5% of Direct Costs)	$13,018
Total Contractual	$117,401

TOTAL DIRECT EXPENSE:	**$711,871**
I. INDIRECT COST (25% of total salaries)	**$97,424**
TOTAL BUDGET 2018:	**$809,294**

Upload #8

Applicant:	San Francisco Department of Public Health
Application Number:	NU62PS2018003083
Project Title:	San Francisco Dept of Public Health High Impact Prevention
Status:	Submitted
Document Title:	PS18-1802 Component B Budget Justification

San Francisco Department of Public Health, SF Division
HIV Prevention Section, Community Health Equity and Promotion
PS18-1802 Integrated HIV Surveillance and Prevention Programs for Health Depts
Component B Budget
01/01/2019-12/31/2019

A. Salaries	$756,148
B. Mandatory Fringe	$297,086
C. Consultant Costs	$0
D. Equipment	$0
E. Materials and Supplies	$3,789
F. Travel	$7,458
G. Other Expenses	$57,331
H. Contractual	$689,152
Total Direct Costs	**$1,810,963**
I. Indirect Costs (25% of Total Salaries)	$189,037
TOTAL BUDGET	**$2,000,000**

A. SALARIES AND WAGES $756,148

Position Title and Name	Annual	FTE	Months	Amount Requested
Director, Population Health Division, and Principal Investigator (PI) T. Aragon, MD, DrPH	NA		12	In-Kind
Deputy Director, Population Health Division C. Siador, MPH	NA		12	In-Kind
Director, Community Health and Equity Promotion Branch T. Packer, MPH	NA		12	In-Kind
Director, Disease Prevention and Control S. Philip, MD, MPH	NA		12	In-Kind
Director, HIV Surveillance, ARCHES S. Scheer, PhD, MPH	NA		12	In-Kind
LINCS Director, Darpun Sachdev, MD	NA		12	In-Kind
Medical Director, City Clinic S. Cohen, MD, MPH	NA		12	In-Kind
Health Educator/Project Manager, Hanna Hjord, MPH	NA		12	In-Kind
Health Program Coordinator II/Prevention Services Outreach Team Coordinator (TBD)	NA		12	In-Kind
Health Program Coordinator III/ Community Programs for Drug Users (Eileen Loughran)	$114,114	50%	12	$57,057
Health Program Coordinator II/Homeless Outreach Coordinator (TBD)	$83,876	100%	12	$83,876
Health Worker II/Homeless Engagement Specialist (TBD)	$56,784	50%	12	$28,392
Health Worker III/San Francisco Health Network Based Navigator (HIV Related Navigator) (TBD)	$62,140	100%	12	$62,140

Public Health Nurse (TBD)	$159,458	50%	12	$79,729
Health Worker III/San Francisco Health Network Based Navigator (TBD)	$62,140	100%	12	$62,140
Health Worker III/San Francisco Health Network Based Navigator (TBD)	$62,140	100%	12	$62,140
Nurse Practitioner/Public Health Detailer (TBD)	$183,014	80%	12	$146,411
Epidemiologist I/Data to Care & PrEP Specialist (TBD)	$74,646	100%	12	$74,646
Junior Administrative Assistant (TBD)	$65,546	100%	12	$65,546
Health Worker II/HIV-Related Navigator (Jails) (TBD)	56,784	60%	12	$34,070

Job Description: Director, Population Health Division and PS 18-1802 Principal Investigator (T. Aragon) This position is in-kind. Dr. Aragón is the San Francisco Health Officer and the Director of the Population Health Division (PHD) of SFDPH. Dr. Tomas Aragón provides overall leadership of the project. Dr. Aragón is responsible for overall planning, implementation, monitoring, and reporting of the program. Dr. Aragon also provides oversight for the Continuous Quality Improvement (CQI) and evaluation activities.

Job Description: Deputy Director, Population Health Division (C. Siador) Ms. Siador is the Business Official for this cooperative agreement. This position is in-kind. She has overall budget/grant oversight authority, and works closely with Finance, Budget and Contracts departments to oversee that grant deliverables are met by established deadlines. As one of the project sponsors, she will provide guidance and input as needed.

Job Description: Director, Community Health Equity and Promotion Branch and Project Co-Director (T. Packer) — This position is in-kind. Ms. Packer is a Project Co-Director for both Component A and Component B, the *OPT-IN* Demonstration Project, and is responsible for overseeing the community-based HIV prevention efforts including community planning, training capacity building, and the Prevention Services Outreach Team. As part of the leadership team she participates in all CQI activities.

Job Description: Director, Disease Control and Prevention Branch and Project Co-Director (S.

Philip) – This position is in-kind. Dr. Philip is a Project Co-Director for both Component A and Component B, the *OPT-IN* Demonstration Project, and is responsible for overseeing the disease control and prevention arm of both components. Dr. Philip works closely with other co-directors and project leads to monitor all short-term outcomes and maintain smooth implementation of all project strategies. This position shares the lead role in the CQI activities and is responsible for tracking and reporting all activities to CDC annually.

Job Description: PS 18-1802 Project Co-Director, and Director of HIV Surveillance (S. Scheer) - This position is in-kind. Dr. Susan Scheer is a Project Co-Director for both Component A and Component B, the *OPT-IN* Demonstration Project and is responsible for management and oversight of HIV surveillance data, creating and maintaining protocols to ensure coordination between the HIV surveillance and the LINCS team and managing the epidemiologists working on the PrEP surveillance and data to care activities. As part of the leadership team, Dr. Scheer plays a role in the CQI activities as well as oversees staff leading the evaluation activities.

Job Description: Director of LINCS Program, (D. Sachdev). Dr. Sachdev provides overall medical supervision and oversight to the LINCS team (Linkage, Integration, Navigation and Comprehensive Services). This position is in-kind. She oversees the SFDPH linkage and partner services for newly-diagnosed clients, and navigation and retention efforts for clients who have fallen out of care. Dr. Sachdev and staff work closely with ARCHES to use the most recent and best quality data to link and monitor clients and implement CQI of the LINCS program.

Job Description: Director of Clinical Prevention, Medical Director, San Francisco City Clinic (S. Cohen) This position is in-kind. Dr. Cohen is the Medical Director of City Clinic (the municipal STD clinic) and Co-Principal Investigator of the NIAID-funded US PrEP Demonstration Project. Dr. Cohen provides overall supervision and oversight to the clinic, to the embedded PrEP and PEP programs and other testing services provided. She assists with activities related to provider capacity building, development and dissemination of protocols for PrEP delivery, and development and implementation of tools to support PrEP uptake and adherence.

Job Description: Health Educator I/Project Manager (H. Hjord) This position is in-kind. The Project Manager is the main point of contact for all communication and evaluation activities for this project, and closely tracks progress on performance measurement activities with the support of the *OPT-IN* Project Co-Directors. This position also plays an active role in all CQI activities, coordinates meetings and activities, and serves as a liaison between the multiple partners that make this project possible.

Job Description: Health Program Coordinator II /Prevention Services Outreach Team Coordinator- (TBD). This position is in-kind. The Health Program Coordinator will provide oversight to the Prevention Services Outreach Team and implement activities of the Homeless Engagement Specialist and the Community Health Response Team. The Health Program Coordinator will act as liaison between the collaborating partners such as Disease Prevention and Control LINCS Navigators, Street Medicine, and outreach teams at community based

organizations. This position is responsible for the day-to-day community Prevention and Services Outreach Team activities. The Coordinator develops the protocols, policies, and procedures for the outreach and encampment activities of the project, and supervises the Prevention and Services Outreach Team. This position will work with the Clinical Services Coordinator to coordinate encampment fairs and outreach sessions and will bring Prevention Services Outreach Team services to other organizations serving homeless individuals, as well as coordinate and provide the training for partners. This position supervises the Homeless Engagement Specialist and is responsible for overseeing the work of the community-based organizations providing services in partnership with Prevention and Services Outreach Team.

Job Description: Health Program Coordinator III/ Coordinator of Community Programs for Drug Users (E. Loughran) The Coordinator works with the Project Co-Directors and leadership team to manage the *OPT-IN* project components related to community service delivery, and supervises the PSOT Coordinator. Represents the project for the department with community partners and stakeholders and other city departments. The HPCIII will work within the health department and across other city departments to develop plans and implement drug user health. The role includes community engagement and response to the health of drug users and people experiencing homelessness.

Job Description: Health Worker III / Care Coordinator (3 positions) works closely with the medical and intensive case management teams to ensure *OPT-IN* clients remain engaged in clinical care after re-linkage to care. The Care Coordinator conducts panel management for *OPT-IN* clients to ensure care transitions occur successfully and patients stay retained. For re-linked patients, the Care Coordinator provides appointment reminders and follows up on missed visits with direct outreach. They also conduct reassessment with *OPT-IN* patients every 90-120 days for up to 12 months during enrollment. They coordinate with formal/informal supports and work with partners to develop an integrated Comprehensive Care Plan. Finally, they oversee the implementation of the care plan with the support of the ICM and OPT-IN team as appropriate.

Job Description: Public Health Nurse (TBD) The Public Health Nurse will work as part of the OPT-IN team to provide care coordination, write prescriptions for buprenorphine, and provide directly-observed therapy for HIV, HCV and potentially PrEP medications and will make warm hand-offs for more complex patients with psychiatric issues.

Job Description: Health Worker II/ Homeless Engagement Specialist (TBD) This position is primarily an outreach position that gathers input and feedback from the priority populations and *OPT-IN* clients as well. This person plays a key role in establishing a relationship with the populations *Project OPT-IN* is trying to reach. The person is the "friendly face" of the OPT-IN team, getting to know the communities being served and continually asking them about their needs and ways to meet them, conducting risk assessments, and providing referrals to community agencies on the OPT-IN team or street medicine staff as appropriate. The Health Worker II will work with collaborating partners such as Disease Prevention and Control LINCS Navigators, Street Medicine, and outreach teams at community based organizations. The

health worker will support the work of the Street Medicine team and Care Coordinator/Navigators through engaging with people who use drugs and people who are homeless.

Job Description: Nurse Practitioner (NP)/Academic Detailer (TBD) – This position is the front-line academic detailer reaching out to providers to explain HIV-related topics, including how to make referrals to *Project OPT-IN* services, to their peers within 15- 20 minutes. The NP provides information, links providers to additional technical support for providing HIV-related services and reducing barriers.

Job Description: Epidemiologist I/Data to Care & PrEP Surveillance Specialist (TBD) – This position is responsible for using STD surveillance and HIV testing data to identify those with greatest need for PrEP, so that a PrEP navigator can reach out to them and offer support for linkage to PrEP services. In addition, the Specialist will prepare NIC lists for the priority populations (homeless, PWID, women, etc.) for OPT-IN navigators.

Job Description: Junior Management Assistant (TBD) - The Junior Management Assistant performs the general administrative and/or management functions for ARCHES. The essential functions of the job primarily include support OPT-IN to reduce HIV-related disparities across the spectrum of prevention, care, and treatment for homeless populations living with and at risk for HIV. These functions include: performing administrative and management functions pertaining to project operations, grant development, and support services. Will assist in the preparation of project reports and presentations; coordinating clerical and technical support activities; preparing meeting materials; attending project, branch, and division meetings; gathering, compiling, and analyzing project-based performance data.

Job Description: Health Worker II (TBD)- This is a jail-based position that is connected to the OPT-IN team and is responsible for HIV and HCV testing, pre- and post-release linkage to care, and related services. These services will include developing and facilitating overdose prevention workshops, including provision of naloxone training , conducting targeted outreach to self-identified opiate users within the various county jail facilities, placing naloxone kits in the property of interested participants for access post-release, disclosure of positive HIV/HCV results to newly diagnosed inmates, meeting with and providing inmates who are already living with HIV/HCV with informational discharge packets on how to access HIV/HCV treatment services within San Francisco.

B. FRINGE BENEFITS (42% of total salaries)	$297,086
C. CONSULTANT COSTS	$0
D. EQUIPMENT	$0

E. MATERIALS/SUPPLIES $3,789

Item	Rate	Cost
Office Supplies	$316/month x 12 months	$3,789

Office Supplies: Funds will cover the cost of basic office supplies for staff including but not limited to pens, paper, folders, binders, presentation materials and other items used on a daily basis.

F. TRAVEL $7,458

Travel		Rate	Quantity	Cost
Local Travel	Muni Pass	$78/mo.	x 6 mo. x 5 staff = 2,340	$2,940
	Ride Sharing	$25/ride	X 24 rides = 600	
CDC Annual Meeting	Airfare	$650/traveler	x 3 travelers = 1,950	$4,518
	Lodging	$150 per night x 3 nights	x 3 travelers = 1,350	
	Per Diem	$76.5 per day x 4 days	X 3 travelers =918	
	Transportation	$100/traveler	x 3 travelers = 300	

Local Travel: Funds will be used to purchase muni passes for local transportation for the Navigators and Academic Detailing staff as well as ride sharing costs for travel when muni is not reasonably accessible.

CDC Meetings: Three program staff will travel to Atlanta for the annual CDC meeting. GSA rates will be used.

G. OTHER $57,331

Item	Rate	Quantity	Cost
Office Rent	$1.93 sq ft x 250 sq ft x 8.9 FTE	x 12 months	$51,531
Training	Professional development and training approximately $1000/training	x 3 trainings	$3,000
SAS Licenses	$1,400 per license	X 2 licenses	$2,800

Office Rent: Office rent covers expenses of office space rental and maintenance for all FTE included in the budget. Calculations are based on the number of FTE from the City and County of San Francisco (SFDPH) as well as the FTE from fiscal sponsor contract with Public Health Foundations Enterprises (PHFE). Rent is included for fiscal sponsor staff because they sit in SFDPH space and use SFDPH facilities; this cost is not accounted for in either the fiscal intermediary indirect rate or the SFDPH indirect rate.

Training: Funds will cover registration costs for training and development for new staff including but not limited to, supervisor training, project management training, leadership training, racial humility training, as well as continuing education on investigation and navigation skill building.

H. CONTRACTUAL $689,152

Contractor Name (see below for details)	Total Funding
Public Health Foundation Enterprises, Inc.	$244,152
San Francisco AIDS Foundation	$245,000
Glide Foundation	$200,000

1. Name of Contractor: **Public Health Foundation Enterprises, Inc.**

Method of Selection: Request for Qualifications (RFQ) RFQ 27-2015

Period of Performance: 01/01/2018 - 12/31/2018

Scope of Work: Public Health Foundation Enterprises, Inc. (PHFE) is a licensed California Non-profit that has served the not-profit education and research communities for over 45 years. PHFE currently provides fiscal intermediary services to over 200 active contracts and grants, representing approximately $100 million and 1100 employees, and serves a variety of community based organizations as well as city, state, and federal government entities. PHFE is the contractor whose role will be solely to administer the funds that pay for staff members, travel, and consultants that support the goals and objectives of the project. They support all programmatic activities, including but not limited to navigation, project management, coordination, administrative support. San Francisco Department of Public Health is the prime recipient of the funds and is completely responsible for ensuring that grant deliverables are met. The fiscal intermediary agency will be monitored by San Francisco Department of Public Health to ensure they are meeting requirements and objectives. By using a fiscal intermediary, SFDPH saves significant administrative costs and time, and allows for more efficient work with consultants. PHFE will also provide fiscal management and assurance, establish vendor agreements, and provide fiscal related technical assistance to vendors.

Method of Accountability: Annual program and fiscal and compliance monitoring.

Itemized budget and justification: $244,152

a) Salaries and Wages $115,414

Position Title and Name	Annual	FTE	Months	Amount Requested
Patient Navigator (L. Johnson)	$56,860	50%	12	$28,431
Patient Navigator (vice Tom Waddell)	$56,860	50%	12	$28,431
Contact Specialist (vice Jon Brock)	$47,154	100%	10	39,294
Counseling Supervisor (T. Matheson)	$119,800	10%	10	$9,983
Finance and Operations Manager (A. Sogal)	$107,598	10.3%	10	$9,275

Job Description: Patient Navigator (Talishia) – The Navigators are part of the LINCS team and provide short-term navigation for people living with HIV, with the goal of re-linking people to care. Once they receive information from a medical provider about an HIV-positive patient who appears to have fallen out of care, or if the person is identified as not-in-care based on surveillance data, the Navigator finds the patient using various sources. Once a client is found and confirmed to have fallen out of care, the Navigators work with that person to assess barriers to care and help them connect back to care. The navigators also facilitate clients keeping appointment through reminders, and provision of medical transportation, etc. as needed. The Navigators also provide linkage to HCV treatment and PrEP.

Job Description: Patient Navigator (TBH) – The Navigators are part of the LINCS team and provide short-term navigation for people living with HIV, with the goal of re-linking people to care. Once they receive information from a medical provider about an HIV-positive patient who appears to have fallen out of care, or if the person is identified as not-in-care based on surveillance data, the Navigator finds the patient using various sources. Once a client is found and confirmed to have fallen out of care, the Navigators work with that person to assess barriers to care and help them connect back to care. The navigators also facilitate clients keeping appointment through reminders, and provision of medical transportation, etc. as needed. The Navigators also provide linkage to HCV treatment and PrEP.

Job Description: Contact Specialist (TBH) – The contact specialist is part of the LINCS team and takes referrals and locates them for navigation, with the goal of re-linking people to care. Once they receive information from a medical provider about an HIV-positive patient who appears to have fallen out of care, or if the person is identified as not-in-care based on surveillance data, the contact specialist finds the patient using various sources. Once a client is found and confirmed to have fallen out of care, the contact specialist hands the patient off

to a navigator work with that person to assess barriers to care and help them connect back to care. The navigators also facilitate clients keeping appointment through reminders, and provision of medical transportation, etc. as needed. The navigators also provide linkage to HCV treatment and PrEP.

Job Description: Supervising Counselor (T. Matheson) – Tim Matheson, a licensed psychologist, serves as our lead staff trainer. In this role, he conducts routine trainings on motivational interviewing and harm reduction counseling. In addition, he leads a weekly one hour case conference to review difficult cases and builds a shared understanding among OPT-IN staff to increase resilience and improve workforce retention and experience.

Job Description: Finance and Operations Manager (A. Sogal) - The Finance and Operations Manager is responsible for the fiscal management, policy development, and financial reporting of projects related to the PHD and PHFE. She develops budgets, monitors grants, and establishes contracts, sub-contracts, and cooperative agreements in addition to managing FTEs, benefits, budget estimates, and monthly reports to assist with the execution of activities. The Finance and Operations Manager collaborates with PHFE and SFDPH (Accounts Payable, Payroll, Human Resources, and Fiscal) on a regular basis to facilitate project activities

b) Fringe Benefits @ 37.18% $42,911
c) Consultant Costs $0
d) Equipment $0
e) Materials and Supplies $23,699

Item	Rate	Cost
Program Supplies	4 tablets with carrier contract and data plan approximately $2,154/tablet x 4 = $8,616	$23,699
	Health Kits, socks and other supplies for clients approximately $17.96/kit x 450 clients = $8,083	
	700 client incentive cards x $10/card = $7000	

Program Supplies: This line item includes programmatic supplies for work with clients. Mobile devices will be used in the field by the OPT-IN team to conduct patient assessments and collect data. Mobile devices will enable us to collect survey information as needed at higher quality and more efficiently. Mobile data entry would save OPT-IN staff time and allow for more direct interaction with clients. This line also covers the costs of providing incentive cards to clients as well as health kits to assist with outreach and follow-up activities for clients.

f) Travel $0
g) Other Expenses $0

h) Contractual/Consultants $35,000

Item	Cost
Academic Detailing Graphic Design	Approximately $100/hr x 350 hrs = $35,000

Graphic Design Consultant: Cost of designing academic detailing materials and project reports for stakeholders.

i) Total PHFE Indirect Rate 12.5% $27,128
Total PHFE Costs $244,152

2. Name of Contractor: San Francisco AIDS Foundation (SFAF)

Method of Selection: Selected through Request for Proposal (RFP) process RFP # 21-2010

Period of performance: 01/01/18-12/31/18

Scope of Work: In collaboration with the SFDPH LINCS and CHRT teams, the San Francisco AIDS Foundation will provide street-based outreach services, HIV and Hepatitis testing, linkage to OPT-IN services and/or other HIV care, linkage to HCV treatment, prevention case management or intensive case management and syringe access services as appropriate.

Itemized budget and justification: Total Budget $245,000. Itemized justification will be provided once contract negotiated to CDC.

3. Name of Contractor: Glide Foundation

Method of Selection: Selected through Request for Proposal (RFP) process RFP # 30-2015

Period of performance: 01/01/18-12/31/18

Scope of Work: In collaboration with the OPT-IN team, the Glide Foundation will provide street-based outreach services, HIV and Hepatitis testing, linkage to OPT-IN and/or other HIV care, linkage to HCV treatment, prevention case management or intensive case management and syringe access services as appropriate. SFAF will also expand services currently being provided at their Harm Reduction Center to provide clients with storage space, additional drop-in services and medication distribution.

Itemized budget and justification: Total Budget $200,000. Itemized justification will be provided once contract negotiated to CDC.

TOTAL DIRECT COSTS:	**$1,810,963**
I. **INDIRECT COSTS** (25% of total salaries)	$189,037
Please see attached indirect cost memo for details.	
TOTAL BUDGET:	**$2,000,000**

HIV Community Planning Council
Attachment B

Ron Hernandez		(415) 867-7482	rhonhern@yahoo.com
Bruce Ito	Mayor's Office of Housing and Community Development	(415) 701-5558	bruce.ito@sfgov.org
Lee Jewell		(415) 552-5552	rljinsf@gmail.com
Dominique Johnson		(415) 808-9527	dominiquerjohnson48@yahoo.com
Juba Kalamka	St. James Infirmary	(415) 554-8494	juba.kalamka@stjamesinfirmary.org
Thomas Knoble **Government Co-Chair**	CHEP	(415) 437-6214	thomas.knoble@sfdph.org
T.J. Lee-Miyaki	San Francisco AIDS Foundation, Positive Force	(415) 724-1272	tjleeinsfca@gmail.com
Helen Lin	Ward 86	(415) 577-9579	Helen.Lin@ucsf.edu
Jessie Murphy	UCSF, Alliance Health Project	(415) 502-7583	jessie.murphy@ucsf.edu
Ney Nascimento	Shanti Project		rnascimento@shanti.org
Irma Parada	DPH, Jail Health Services	(415) 581-3141	irma.parada@sfdph.org
Ken Pearce		(415) 863-3304	kwpsf2@gmail.com
Wayne Rafus	LGBT Center	(510) 228-2654	wayner@sfcenter.org
Darpun Sachdev	DPH, LINCS	(415) 487-5501	darpun.sachdev@sfdph.org
Michael Shriver **Community Co-Chair**		(415) 235-0464	dadanation@gmail.com
Charles Siron		(415) 655-3008	charlessiron@gmail.com
Gwen Smith	DPH, Southeast Health Center	(415) 671-7057	gwensmith@sfdph.org

HIV Community Planning Council
Attachment B

Michelle Spence	UCSF, Women's Specialty Clinic	(415) 353-7670	Leborah.Spence@ucsf.edu
John Paul Soto	Lutheran Social Services of Northern California	(415) 581-0891	jpsoto@lssnorcal.org
Eric Sutter	Shanti Project	(415) 674-4754	esutter@shanti.org
Laura Thomas	SF AIDS Foundation	(415) 283-6366	lthomas@drugpolicy.org
Linda Walubengo **Community Co-Chair**	SF AIDS Foundation	(571) 340-7876	lwalubengo@catholiccharitiessf.org
Mark Molnar	Program Director, Volunteer and Community Support Services (VCSS)	(415) 674-4726	mmolnar@shanti.org
Ali Cone	Program Manager, VCSS	(415) 674-4751	acone@shanti.org
Dave Jordan	Program Manager, HCPC	(415) 674-4720	djordan@shanti.rog
Melina Clark	Program Coordinator	(510) 301-6977	mclark@shanti.org

City and County of San Francisco
London N. Breed
Mayor

Department of Public Health
Grant Colfax, MD
Director of Health

August 22, 2019

Angela Calvillo, Clerk of the Board of Supervisors
Board of Supervisors
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, CA 94102-4689

RE: Resolution authorizing the San Francisco Department of Public Health (SFDPH) to apply for the Integrated HIV Surveillance and Prevention Programs for Health Departments (CDC)

Dear Ms. Calvillo:

Attached please find an original and four copies of a proposed resolution for the approval of the Board of Supervisors, which authorizes the San Francisco Department of Public Health (SFDPH) to submit an application to the Centers for Disease Control and Prevention (CDC) for the **Integrated HIV Surveillance and Prevention Programs for Health Departments** grant. This application represents approximately $7,008,377 in HIV prevention & surveillance and Component B funding for San Francisco for calendar year 2020.

This resolution is required by Ordinance No. 265-05, which amends Section 10-170 of the Administrative Code to require Board of Supervisors review of recurring grant applications of $5,000,000 or more prior to their submission. SFDPH received from CDC the application guidance on July 25, 2019. The application deadline is September 16, 2019

I hope that the Board will support this resolution. If you have any questions regarding the City and County Plan or this resolution, please contact Tracey Packer, Director of Community Health Equity & Promotion.

Sincerely,

Grant Colfax, MD
Director of Health

Enclosures
cc: Tomas Aragon, Director of the Population Health Division
Christine Siador, Deputy Director of the Population Health Division
Tracey Packer, Director of Community Equity & Health Promotion

OFFICE OF THE MAYOR
SAN FRANCISCO

LONDON N. BREED
MAYOR

RECEIVED
BOARD OF SUPERVISORS
SAN FRANCISCO
2019 SEP 24 PM 3:34
BY

TO: Angela Calvillo, Clerk of the Board of Supervisors
FROM: Sophia Kittler
RE: Grant Application – Centers for Disease Control and Prevention - Integrated HIV Surveillance and Prevention Programs for Health Departments - $7,008,377
DATE: Tuesday, September 23, 2019

Resolution authorizing the Department of Public Health to submit a one-year application for calendar year 2020 to continue to receive funding for the Integrated HIV Surveillance and Prevention Programs for Health Departments from the Centers of Disease Control and Prevention, requesting $7,008,377 in HIV prevention funding for San Francisco from January 1, 2020 through December 31, 2020.

Please note that Supervisor Mandelman is a co-sponsor.

Should you have any questions, please contact Sophia Kittler at 415-554-6153.

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