File No. 151194 Committee Item No. 14
Board Item No. _____

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget & Finance Committee **Date** January 20, 2016

Board of Supervisors Meeting **Date** _____

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** January 15, 2016
Completed by: Linda Wong **Date** _____

FILE NO. 151194 RESOLUTION NO.

[Accept and Expend Grant - Centers for Disease Control and Prevention - San Francisco PrEP and Data to Care Demonstration Projects - $2,898,913]

Resolution retroactively authorizing the San Francisco Department of Public Health to accept and expend a grant in the amount of $2,898,913 from Centers for Disease Control and Prevention to participate in a program entitled San Francisco PrEP and Data to Care Demonstration Projects for the period of September 30, 2015, through September 29, 2016.

WHEREAS, Centers for Disease Control and Prevention has agreed to fund Department of Public Health (DPH) in the amount of $2,898,913 for the period of September 30, 2015, through September 29, 2016; and

WHEREAS, The full project period of the grant starts on September 30, 2015, and ends on September 29, 2018, with years two and three subject to availability of funds and satisfactory progress of the project; and

WHEREAS, As a condition of receiving the grant funds, Centers for Disease Control and Prevention requires the City to enter into an agreement (Agreement), a copy of which is on file with the Clerk of the Board of Supervisors in File No. 151194; which is hereby declared to be a part of this Resolution as if set forth fully herein; and

WHEREAS, The purpose of this project will enable Category 1 funding for DPH to implement high-impact, evidence-based strategies to improve uptake of PrEP among people at substantial risk for HIV in San Francisco, especially MSM of color and transwomen who have sex with men; and

WHEREAS, Category 2 funding will enable DPH to expand current efforts to use HIV surveillance data (Data to Care) to help increase the proportion of HIV-diagnosed MSM and

transwomen who have sex with men in San Francisco who are virally suppressed, especially for people of color; and

WHEREAS, An Annual Salary Ordinance amendment is not required as the grant partially reimburses DPH for seventeen existing positions, one Manager I (Job Class No. 0922) at .20 FTE, one Disease Control Investigator (Job Class No. 2806) at .50 FTE, one Medical Social Worker (Job Class No. 2920) at .10 FTE, one Senior Administrative Analyst (Job Class No. 1823) at .20 FTE, one Junior Management Assistant (Job Class No. 1840) at 1.0 FTE, one Nurse Practitioner (Job Class No. 2328) at 1.0 FTE, four Health Worker III (Job Class No. 25870 at 1.0 FTE, one Health Program Coordinator I (Job Class No. 2589) at 1.0 FTE, one Health Program Coordinator III (Job Class No. 2593) at 1.0 FTE, one Epidemiologist II (Job Class No. 2803) at 1.0 FTE, three Epidemiologist I (Job Class No. 2802) at 3.0 FTE, and one Health Educator (Job Class No. 2822) at 1.0 FTE for the period of September 30, 2016, through September 29, 2016; and

WHEREAS, A request for retroactive approval is being sought because DPH had administrative delays in processing the application, for a project start date of September 30, 2015; and

WHEREAS, The budget includes a provision for indirect costs in the amount of $308,112; now, therefore, be it

RESOLVED, That DPH is hereby authorized to retroactively accept and expend a grant in the amount of $2,898,913 from Centers for Disease Control and Prevention; and

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

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

RECOMMENDED:

for

Barbara A. Garcia, MPA
Director of Health

APPROVED:

Office of the Mayor

for Office of the Controller

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

Grant Resolution Information Form
(Effective July 2011)

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

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

1. Grant Title: **San Francisco PrEP and Data to Care Demonstration Projects**

2. Department: **Population Health Division, Disease Prevention and Control Branch**

3. Contact Person: **Susan Philip, MD, MPH** Telephone: **(415) 355-2007**

4. Grant Approval Status (check one):

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

5. Amount of Grant Funding Approved or Applied for:
$2,898,913 Year 1*
$2,898,913 Year 2
$2,898,913 Year 3
$8,696,739 Total for Project
***DPH is seeking accept & expend approval for Year 1 only. The funder will approve subsequent years based on satisfactory programmatic progress and the availability of funds. Future funding will be included in the DPH budget.**

6a. Matching Funds Required: **N/A**
b. Source(s) of matching funds (if applicable): **N/A**

7a. Grant Source Agency: **Department of Health & Human Services, Centers for Disease Control and Prevention**
b. Grant Pass-Through Agency (if applicable): **N/A**

8. Proposed Grant Project Summary:
The City and County of San Francisco (SF) was one of the first and hardest hit epicenters of the HIV epidemic. As of December 31, 2013, SF had 15,901 residents living with HIV – 13% of California's living HIV cases. Nine out of every 10 living HIV cases in SF are among men who have sex with men (MSM). Locally, MSM continue to be disproportionately impacted by HIV, comprising 86% of all HIV cases newly diagnosed in 2013, with 27% of new diagnoses among MSM of color.1 The good news is that new infections are decreasing, and in 2014 multiple individuals and organizations including the San Francisco Department of Public Health (SFDPH) established the multi-sector, independent Getting to Zero Consortium (G2Z), with the long-term goal of Zero HIV infections, Zero HIV Deaths, and Zero HIV stigma in San Francisco. Its short-term goal is to reduce both HIV infections and HIV deaths by 90% from their current levels by 2020. The G2Z strategic plan describes a comprehensive approach with three signature initiatives which relate directly to the strategies supported through this CDC grant: 1) Pre-Exposure Prophylaxis (PrEP) expansion, 2) Provision of antiretroviral therapy in the setting of acute HIV infection or upon diagnosis and 3) Retention in HIV care.

The grant project activities align with SFDPH and G2Z strategic priorities and the National HIV/AIDS Strategy goals of reducing new HIV infections, and reducing HIV-related disparities and health inequities. Funding for Category 1 will enable us to implement high-impact, evidence-based strategies to improve uptake of PrEP among people at substantial risk for HIV in SF, especially MSM of color and transwomen who have sex with men. Our jurisdiction is keenly aware that PrEP is a critical tool to reduce HIV infections among persons at substantial risk of acquiring HIV and optimizing the health outcomes of people living with HIV. Category 2 funding will enable us to expand our current efforts to use HIV surveillance data (Data to Care) to help increase the proportion of HIV-diagnosed MSM and transwomen who have sex with men in SF who are virally suppressed, especially for people of color. Our jurisdiction is keenly aware that Data to Care is a critical tool to reduce HIV infections among persons at substantial risk of acquiring HIV and optimizing the health outcomes of people living with HIV.

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

Approved Year one project:	**Start-Date:**	**09/30/15**	**End-Date: 09/29/16**
Full project period:	**Start-Date:**	**09/30/15**	**End-Date: 09/29/18**

10a. Amount budgeted for contractual services: **$617,514**

b. Will contractual services be put out to bid? **Yes**

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

d. Is this likely to be a one-time or ongoing request for contracting out? Ongoing

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

b1. If yes, how much? **$308,112**
b2. How was the amount calculated? **24.03% of total salaries**

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

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

12. Any other significant grant requirements or comments:
We respectfully request approval to accept and expend these funds retroactive to September 30, 2015. The Department received the original notice on September 8, 2015.

GRANT CODE (Please include Grant Code and Detail in FAMIS): HCAC12/1600

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

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

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

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

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

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

Comments:

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

Ron Weigelt
(Name)

Director of Human Resources and Interim Director, EEO, and Cultural Competency Programs
(Title)

Date Reviewed: 10-26-15

Darlene C. Daeun
(Signature Required)

Department Head or Designee Approval of Grant Information Form:

Barbara A. Garcia, MPA
(Name)

Director of Health
(Title)

Date Reviewed: 10/27/15

for
(Signature Required)

San Francisco PrEP and Data to Care Demonstration Projects
Budget Narrative
September 30, 2015 – September 29, 2016

	Category 1 PrEP	Category 2 Data to Care	Total
A. Salaries and Wages	$845,382	$436,814	$1,282,196
B. Mandatory Fringe	$355,061	$183,462	$538,523
C. Consultant Costs	$0	$0	$0
D. Equipment	$0	$0	$0
E. Materials and Supplies	$17,040	$15,360	$32,400
F. Travel	$6,440	$6,420	$12,860
G. Other Expenses	$65,479	$41,829	$107,308
H. Contractual	$448,462	$169,052	$617,514
Total Direct	**$1,737,864**	**$852,937**	**$2,590,801**
I. Indirect Costs (24.03% on salaries)	$203,145	$104,967	$308,112
Total Budget	**$1,941,009**	**$957,904**	**$2,898,913**

The program and work plan will be accomplished by the San Francisco Department of Public Health (SFDPH). The core team at SFDPH will be supported by the Public Health Foundation Enterprises, Inc. (PHFE). PHFE is a licensed California Non-profit that has served the not-for 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 a subcontractor to SFDPH on this proposal and will provide high quality fiscal intermediary services, particularly in the area of accounting, human resources, and contract and grant management. These services include accounts payable and payroll processing, budgeting, monthly expense and cost reporting, subcontract management, compliance with financial audits, personnel services, recruitment, and management of confidential personnel records. For more information on PHFE's role please see the scope of work under the subcontract line item.

In order to meet the requirement of allocating a minimum of 10% of our resources towards evaluation, we are allocating resources as shown in the table below. For more information, please refer to the details in the justification.

Evaluation Staffing	Requested Funds	% Evaluation	Total $ Evaluation
Director, ARCHES S. Scheer, PhD, MPH	$34,209	5%	$1,710
Health Program Coordinator III/Lead PrEP Coordinator (TBD)	$148,865	25%	$37,216
Health Educator/PrEP Communication (TBD)	$135,603	10%	$13,560
Health Program Coordinator I /PrEP Training (TBD)	$131,603	10%	$13,160
Health Worker III/PrEP Navigator(TBD)	$97,140	10%	$9,714
Nurse Practitioner/Academic Detailer (TBD)	$287,453	5%	$14,373
Disease Investigator Specialist/PrEP Champion S. Penn	$53,010	5%	$2,651
Junior Management Assistant/ Program Assistant (TBD)	$102,430	5%	$5,122
Epidemiologist II /Lead Data to Care Coordinator and Lead Evaluator (TBD)	$148,865	50%	$74,433
Epidemiologist I/PrEP Surveillance Specialist (TBD)	$116,636	15%	$17,495
Epidemiologist I/Data to Care Specialist (TBD)	$116,636	15%	$17,495

Evaluation Staffing	Requested Funds	% Evaluation	Total $ Evaluation
Epidemiologist I/Informatics/System Designer (TBD)	$116,636	15%	$17,495
Health Worker III/Data to Care Navigators (3 TBD)	$291,421	10%	$29,142
Agency Subcontracts for POL	$145,000	10%	$14,500
Social Marketing Contract	$150,000	10%	$15,000
PHNIX Developer Contracts (Consilience and SSG)	$150,000	10%	$15,000
Total Funding Allocated To Evaluation Activities (approximately 10.28%)			**$298,066**

A. TOTAL SALARIES AND WAGES **$1,282,196**

Category 1 PrEP Salaries $845,382

Category 2 Data to Care Salaries $436,814

Salaries and Wages: City and County of San Francisco Personnel

Position Title and Name	Annual	FTE PrEP	FTE Data to Care	Months	Amount Requested
Principal Investigator (PI) and Director, Population Health Division T. Aragon, MD, DrPH	NA	5%	5%	12	In-Kind
Project Director and Director, Disease Prevention and Control S. Phillip, MD, MPH	NA	15%	5%	12	In-Kind
Director, ARCHES S. Scheer, PhD, MPH	$120,453	5%	15%	12	$24,091
Medical Director, City Clinic S. Cohen, MD, MPH	NA	5%	5%	12	In-Kind
Director, Community Health and Equity Promotion Branch T. Packer, MPH	NA	5%		12	In-Kind
Director, Office of Equity and Quality Improvement I. Nieves	NA	5%	5%	12	In-Kind
Public Health Informatics Officer J. Grinsdale, MPH	NA		10%	12	In-Kind

Position Title and Name	Annual	FTE PrEP	FTE Data to Care	Months	Amount Requested
Director, Center for Learning and Innovation J. Fuchs, MD, MPH	NA	5%		12	In-Kind
Director, Bridge HIV S. Buchbinder, MD	NA	5%		12	In-Kind
Director of Clinical Research, BridgeHIV A. Liu, MD	NA	5%		12	In-Kind
Health Program Coordinator III/Lead Coordinator of PrEP Program (TBD)	$103,265	100%		12	$103,265
Health Educator/PrEP Communication (TBD)	$95,495	100%		12	$95,495
Health Program Coordinator I /PrEP Training (TBD)	$92,329	100%		12	$92,329
Health Worker III/PrEP Navigator(TBD)	$68,409	100%		12	$68,409
Nurse Practitioner/Academic Detailer (TBD)	$202,432	100%		12	$202,432
Disease Investigator Specialist/PrEP Champion S. Penn	$74,661	50%		12	$37,331
Junior Management Assistant/ Program Assistant (TBD)	$72,134	75%	25%	12	$72,134
Medical Social Worker A. Scheer	$94,883		10%	12	$9,488
Senior Epidemiologist II /Lead Data to Care Coordinator and Lead Evaluator (TBD)	$104,835	50%	50%	12	$104,835
Epidemiologist I/PrEP Surveillance Specialist (TBD)	$82,138	100%		12	$82,138
Epidemiologist I/Data to Care Specialist (TBD)	$82,138		100%	12	$82,138
Epidemiologist I/Informatics/System Designer (TBD)	$82,138	50%	50%	12	$82,138
Health Worker III/Data To Care Navigators (3 TBD)	$68,409		300%	12	$205,226
Senior Administrative Analyst L. Garrido	$103,744	10%	10%	12	$20,747

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

Job Description: Project Director and Director, Disease Control and Prevention (S. Philip) – This position is in-kind. Dr. Philip is the Project Director for both Category 1 PrEP and Category 2 Data to Care. Dr. Philip is the Director for Disease Prevention and Control for PHD. Dr. Philip will be responsible for supervising and training the PrEP Coordinator, and will work closely with other project leads to monitor all short-term outcomes and maintain smooth implementation of all project strategies. She will play a lead role in the CQI activities and will be responsible for tracking and reporting all activities to CDC annually, under the supervision of Dr. Aragón.

Job Description: Director of the Applied Research, Community Health Epidemiology, and Surveillance (ARCHES) (S. Scheer) - Dr. Susan Scheer is the Director of the ARCHES Branch of PHD. Dr. Scheer has overseen HIV surveillance activities in San Francisco for over 10 years. Dr. Scheer will be 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, she will play a role in the CQI activities as well as oversee staff leading the evaluation activities. Dr. Scheer will dedicate 5% of her time towards evaluation.

Job Description: Medical Director, 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. She also provides overall supervision and oversight to the Linkage, Integration, Navigation and Comprehensive Services (LINCS) team. She will assist 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. In addition, she will oversee CQI of the LINCS navigation program.

Job Description: Director, Community Health Equity and Promotion Branch (T. Packer) — This position is in-kind. As Director of Community Health Equity and promotion, Ms. Packer will oversee coordination and collaboration with community based organizations and other community partners. In addition, she will oversee the work of the Health Educator with community-based organizations and community members, and as part of the leadership team she will participate in CQI activities.

Job Description: Director, Office of Equity & Quality Improvement (I. Nieves) – This position is in-kind. As Director of the Office of Equity & Quality Improvement, Mr. Nieves will take the lead in facilitating all CQI activities and participate as part of the leadership team.

Job Description: Public Health Informatics Officer (J. Grinsdale) – This position is in-kind. Ms. Grinsdale is the Public Health Informatics Officer and lead on PHNIX development data integration project. Ms. Grinsdale is a trained epidemiologist and public health informatician who has worked on public health information systems development, use of surveillance and program data for improving public health intervention outcomes, and program evaluation. She will contribute to the management and oversight of data integration and PHNIX system enhancements. As part of the leadership team, Ms. Grinsdale will participate in CQI activities.

Job Description: Director, Center for Learning and Innovation (J. Fuchs) – This position is in-kind. Dr. Fuchs is the Director of the Center for Learning and Innovation for PHD and is the PI of a CDC-funded Capacity Building Assistance Program to health departments nationally under PS14:1403. He will oversee the work of cataloguing existing and creating new materials to support provider implementation of PrEP. He will also oversee the online and videoconferencing activities to support the Communities of Practice (COPs). As part of the leadership team, he will work participate in the CQI process.

Job Description: Director, Bridge HIV (S. Buchbinder) – This position is in-kind. Dr. Buchbinder is the Director of Bridge HIV and an expert in the field of bio-behavioral HIV prevention. She will provide feedback and guidance on the PrEP activities. Dr. Buchbinder is also the Steering Committee Head for the Getting to Zero Consortium. As part of the leadership team she will help coordinate efforts, maximize resources, and aligning priorities of this program with the larger Getting to Zero initiative and other consortium activities. Dr. Buchbinder will also be part of the CQI activities.

Job Description: Director Clinical Research, Bridge HIV (A. Liu) - Dr. Liu is a world expert on PrEP and adherence to PrEP. He was the Chief Medical Officer of the global iPrEx study, PI of the US PrEP demonstration project and PI of EPIC (Enhancing PrEP in Communities), an ongoing study assessing tools for improving adherence among PrEP users. He will provide input into all aspects of the PrEP activities, particularly related to provider capacity building and measuring and supporting adherence among PrEP users. As part of the leadership team, he will participate in CQI activities.

Job Description: Health Program Coordinator III/Lead PrEP Coordinator (TBD) – The PrEP Coordinator will be responsible for the day-to-day activities of the project. S/he will work with the Project Director and leadership team to manage the PrEP project. S/he will develop the protocols, policies, and procedures for the project, ensure communication throughout the team, coordinate meetings and activities, and serve as a liaison between the multiple partners that make this project possible. The PrEP Coordinator will be the main point of contact for all communication and evaluation activities for this project, and will closely track progress on performance measurement activities with the support of the Project Director. The PrEP Coordinator will also play an active role in all CQI activities. This position will dedicate 25% of his/her time towards evaluation.

Job Description: Health Educator/PrEP Communication (TBD) – The Health Educator will support the PrEP Coordinator on all project activities and provide health education expertise throughout the project. S/he will assist in the details of protocol development and dissemination, oversee the focus group and other formative evaluation with community members, coordinate training activities with the Health Program Coordinator I below, and provide other support needed for the project. This person will oversee and provide technical assistance to the subcontracted agencies conducting the Popular Opinion Leader intervention activities, the social network program, and will be responsible for working with the social marketing subcontractor. This position will dedicate 10% of his/her time towards evaluation.

Job Description: Health Program Coordinator I (TBD) – This position will be housed in the Center for Learning and Innovation. Along with the Health Educator, this position will be responsible for development, compilation, and dissemination of PrEP informational tools for providers. In addition, this person will recruit for, manage and facilitate the Communities of Practice. This position will dedicate 10% of his/her time towards evaluation.

Job Description: Health Worker III/PrEP Navigator (TBD) –The position will be part of the LINCS team and will offer PrEP navigation support using social networking/hookup apps such as Grindr, SCRUFF, GROWLr, Hornet, and BarebackRT, by maintaining an account and being available to answer questions about PrEP to app users, help organize and speak at PrEP-related Town Halls (presentations at churches, community centers, bars, etc.) and participation in events such as the Gay Pride parade or Castro Street Fair, offer PrEP navigation services online, including the PleasePrEPMe website (under development) that provides geolocation of the nearest PrEP clinics, chat-based access to a PrEP navigator to answer questions and provide referrals to community resources, and an online database that allows someone to plug in socioeconomic details (including income and insurance status) and zip code in order to receive information on local providers or eligible benefits (including acceptance of the PrEP Co-pay card), and provide PrEP information through other community-based services. This position will dedicate 10% of his/her time towards evaluation.

Job Description: Nurse Practitioner (NP)/Academic Detailer (TBD) – This position will be the front-line academic detailer reaching out to providers to explain PrEP to their peers within 15-20 minutes. The NP will provide information, link providers to additional technical support for prescribing PrEP and reducing barriers. S/he will work with another NP currently funded through our fiscal intermediary contract with Public Health Foundation Enterprises to oversee and provide all academic detailing responsibilities. This position will dedicate 5% of his/her time towards evaluation.

Job Description: Disease Investigator Specialist (DIS)/PrEP Champion (S. Penn) – Ms. Penn is a highly experienced DIS with extensive experience with HIV and syphilis partner services, and with linking individuals newly diagnosed with HIV to care. Ms. Penn will provide input on protocols (developed by the PrEP Coordinator and LINCS Medical Director) for integrating PrEP referrals into the partner services process. She will provide direct information and referrals for

PrEP to HIV-negative partners of syphilis and HIV cases, and will help train other members of the syphilis and LINCS team. This position will dedicate 5% of his/her time towards evaluation.

Job Description: Junior Management Assistant/Program Assistant (TBD) - The Program Assistant will schedule internal meetings, organize training and site visit logistics, submit travel requests and reimbursements, and assist program staff for both Category 1 PrEP and Category 2 Data Care with other activities as needed. This position will dedicate 5% of his/her time towards evaluation.

Job Description: Medical Social Worker (A. Scheer) – Mr. Scheer will work with subject matter experts (listed as consultants under the fiscal intermediary, PHFE) and with the program coordinator in CLI, to train front-line staff (e.g. social workers, HIV test counselors, health workers) in clinics that provide HIV care and in community based organizations on best practices for patient retention. He will increase capacity for these key staff to help clients navigate the current insurance landscape and access programs to offset the cost of care.

Job Description: Senior Epidemiologist II/Lead Data to Care Coordinator and Lead Evaluator (TBD) – This person will serve as the liaison between HIV surveillance, the PrEP program activities and the linkage and navigation programs. S/he will be responsible for all day-to-day activities for Category 2 Data to Care as well as act as the lead evaluator for both Category 1 PrEP and Category 2 Data to Care. S/he will also conduct the initial analysis of data and the assessment conducted during the first half of year 1. This position will dedicate 50% of his/her time towards evaluation.

Job Description: Epidemiologist I/PrEP Surveillance Specialist (TBD) – This position will be responsible for using STD surveillance and HIV CTR 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. Using the PHNIX data system, scheduled to be launched in year 1, the Epidemiologist will be able to flag individuals who are prime candidates for PrEP and provide their contact information on a real-time basis to navigators. This position will dedicate 15% of his/her time towards evaluation.

Job Description: Epidemiologist I/Data to Care Specialist (TBD) – The epidemiologist will work with HIV surveillance and the linkage and navigation programs to determine the optimal priorities for the NIC list data and formatting. S/he will run all the analyses related to the NIC lists and their development. This epidemiologist will also work with PHNIX staff and developers to examine opportunities to use these data in novel ways and to help build the PHNIX database to create these lists. This position will dedicate 15% of his/her time towards evaluation.

Job Description: Epidemiologist I/Informatics/System Designer (TBD) - The epidemiologist will serve as the project informatician to develop requirements for PHNIX development, develop project reports and dashboards, provide support for developing policies, procedures and protocols as they pertain to data collection and use. This position will dedicate 15% of his/her time towards evaluation.

Job Description: Health Worker III/Data to Care Navigators (TBD) – Three Navigators will join the LINCS team to 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 will find 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. This position will dedicate 10% of his/her time towards evaluation.

Job Description: Senior Administrative Analyst (L. Garrido) – Ms. Garrido will provide fiscal and administrative support to the program. She prepares funding notification letters, manages section budgets and prepares statistical reports on contracts. She will work with program staff and contractors to resolve issues related to invoicing.

B.	**FRINGE BENFITS** (42% of total salaries)	**$538,523**
	Category 1 PrEP Fringe	$355,061
	Category 2 Data to Care Fringe	$183,462
C.	**CONSULTANT COSTS**	**$0**
D.	**EQUIPMENT**	**$0**
E.	**MATERIALS/SUPPLIES**	**$32,400**
	Category 1 PrEP Materials/Supplies	$17,040
	Category 2 Data to Care Materials/Supplies	$15,360

Item	Rate	PrEP	Data To Care	Cost
Office Supplies	$ 50/mo.	x 8.4 FTE x 12 mo. = 5,040	x 5.6 FTE x 12 mo. = 3,360	$8,400
IT Supplies	$2000/computer	x 6 computers = 12,000	x 6 computers = 12,000	$24,000

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.

IT Supplies: This includes but is not limited to the purchase of desktop computers for new staff. The purchase will also include all appropriate software.

F. TRAVEL **$12,860**

Category 1 PrEP Travel $6,440

Category 2 Data to Care Travel $6,420

Travel		Rate	PrEP	Data to Care	Cost
Local Travel	Muni Pass	$70/mo.	x 12 mo. x 1 staff = 840	x 12 mo. x 3 staff = 2,520	$3,360
CDC Annual Meeting	Airfare	$650/ traveler	x 3 travelers = 1,950	x 3 travelers = 1,950	$7,800
	Lodging	$250 per night x 2 nights	x 3 travelers = 1,500	x 3 travelers = 1,500	
	Transportation	$150/ traveler	x 3 travelers = 450	x 3 travelers = 450	
Academic Detailing Training Travel	Airfare	$800/ traveler	x 1 traveler = 800		$1,700
	Lodging	$250 per night x 3 nights	x 1 traveler = 750		
	Airfare	$150/ traveler	x 1 traveler = 150		

Local Travel: Funds will be used to purchase muni passes for local transportation for the Navigators and Academic Detailing staff.

CDC Meetings: Three program staff will travel to Atlanta for the annual CDC meeting for both Category 1 PrEP and Category 2 Data to Care. GSA rates will be used for lodging.

Academic Detailing Training Travel: Funds will be used to send the nurse practitioner to academic detailing training in Massachusetts.

G. OTHER **$107,308**

Category 1 PrEP Other	$65,479
Category 2 Data to Care Other	$41,829

Item	Rate	PrEP	Data to Care	Cost
Office Rent	$1.93/sq.ft./mo. x 250 sq.ft/FTE x 12 mo.	x 9.05 FTE = 52,400	x 5.7 FTE = 33,003	$85,403
Telephone/ Communication	Average monthly cost $15/FTE/mo. x 12 mo.	x 9.05 FTE = 1,629	x 5.7 FTE = 1,026	$2,655
Photocopier lease/ photocopies	Lease approximately $300/mo. Photocopy Cost $100/mo. Total $400/mo.	x 12 mo. = 4,800	x 12 mo. = 4,800	$9,600
Training	Academic Detailing Registration	$650 registration		$9,650
	Professional development and training approximately $500/training	x 12 trainings = 6,000	x 6 trainings = 3,000	

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.

Telephone/Communication: Funds cover expenses for all means necessary to communicate with contractors, partners, health departments, and grantors, including local and long distance telephone calls, fax usage, Internet, voicemail and replacement/maintenance of phones for program staff and administrative staff. 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 PHFE. Phone costs are 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.

Photocopier Lease/Photocopies: Funds cover expenses for office photocopier lease which includes maintenance and the monthly cost of making photocopies for program staff. The monthly photocopy cost is based on the number of copies actually made.

Training: Funds will cover registration costs for the academic detailing training, fees for training and development for new staff, as well as the cost of training of DIS staff on PrEP and continuing education on investigation and navigation skill building.

H.	**CONTRACTUAL**	**$617,514**
	Category 1 PrEP Contractual	$448,462
	Category 2 Data to Care Contractual	$169,052

Contractor Name (see below for details)	PrEP	Data to Care	Total Funding
Public Health Foundation Enterprises, Inc.	153,462	144,052	$297,514
Community Based Agency POL Contracts	145,000		$145,000
Consilience		25,000	$25,000
Better World Advertising	150,000		$150,000

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

Method of Selection: PHFE was selected through a Request for Qualifications process held in 2013 by the SFDPH Contracts Unit. PHFE acts as a fiscal intermediary for SFDPH.

Period of Performance: 09/30/2015 - 09/29/2016

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. The staff employed through the fiscal intermediary are under the supervision of SFDPH staff and sit with SFDPH staff. They support all programmatic activities, including but not limited to 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:

a. Salaries and Wages	$71,781
Category 1 PrEP Salaries and Wages	$64,069
Category 2 Data to Care Salaries and Wages	$ 7,712

Position Title and Name	Annual	PrEP	Data to Care	Months	Amount Requested
Project Manager (J. Balido)	$77,123	15%	10%	12	$19,281
Nurse Practitioner (J. Walker, NP)	$105,00	50%		12	$52,500

Job Description: Project Manager (J. Balido) – Ms. Balido will be responsible for working with the Program Directors and Coordinators to develop the project charter, which will include the roles and responsibilities chart, identification of project stakeholders, identify key assumptions and risks, and development of the project timelines and scopes.

Job Description: Nurse Practitioner (NP) (J. Walker) – Mr. Walker will work in collaboration with the nurse practitioner academic detailing to conduct academic detailing activities around PrEP. The NP will work directly with clinical providers to provide technical support for reducing barriers to prescribing PrEP

b. Fringe Benefits @ 31.1% $22,324
Category 1 PrEP Fringe $19,925
Category 2 Data to Care Fringe $2,399

c. Consultant Costs $12,500
Category 1 PrEP Consultant $0
Category 2 Data to Care Consultant $12,500

Item	Rate	PrEP	Data to Care	Cost
Subject Matter Experts –Retention and Barrier to Care	$125/hour x 100 hours		12,500	$12,500

Subject Matter Experts – Retention and Barriers to Care: Consultants will be hired to provide expertise and training to front-line staff in clinics that provide HIV care and in community based organizations around retention and barriers as well as increasing cross-agency collaboration and developing knowledge of PrEP and PEP. Mr. Scheer, the medical social worker, will help facilitate the use of the consultants.

d. Equipment $0

e. Materials and Supplies $0

f. Travel $5,470
Category 1 PrEP Travel $3,190
Category 2 Data to Care Travel $2,280

Travel		Rate	PrEP	Data to Care	Cost
Local Travel	Muni Pass	$70/mo. x 12 mo.	x 1 staff = 840		$3,120
	Transportation Vouchers	Approximately $190/mo		X 12 mo. = 2,280	
Academic Detailing Training Travel	Registration	$650 registration	x 1 staff = 650		$2,350
	Airfare	$800/traveler	x 1 staff = 800		
	Lodging	$250/night x 3	x 1 staff = 750		
	Transportation	$150/traveler	x 1 staff = 150		

Local Travel: A public transit muni cards will be purchased to cover local travel for the academic detailing staff. In addition transportation vouchers will be purchased and used by LINCS staff for clients to facilitate in ensuring appointments are kept.

Academic Detailing Training Travel: Funds will be used to send the nurse practitioner to academic detailing training in Massachusetts.

g. Other Expenses $156,440
Category 1 PrEP Other $51,320
Category 2 Data to Care Other $105,120

Item	Rate	PrEP	Data to Care	Cost
SSG	Approximately $125/hour	x 400 hours = $50,000	x 600 hours = $75,000	$125,000
Shipping	Approximately $20/month	x 12 months = 120	x 12 months = 120	$240
Contingency Management	$100 in gift cards/client		x 300 clients = 30,000	$30,000
Web Services	$100/mo.	x 12 mo. = 1,200		$1,200

Strategic Solutions Group (SSG): SSG will assist with and support the SFDPH Public Health Informatics Officer in activities around Public Health Network Information Exchange (PHNIX) system. SSG will work with the informatics officer, project informatician, and other team members to develop a scope of work to implement functionality described in the proposal. SSG has an hourly rate of $125/hour and will be paid for up to a maximum of 1000 hours as part of year ones activities. PHNIX system enhancements will be determined during the first six months of the project period and a detailed scope of work for consilience software will be developed at that time. This scope of work will include:

1. System enhancements to support PrEP (400 hours)
2. System enhancements to support Data to Care (400 hours)
3. Interface with CareWare/ARIES (200 hours)

Shipping: Funds for shipping project materials for meetings, general project management and grant administration.

Contingency Management: Contingency management will be offered to improve care retention rates for those members of the priority population who are not virally suppressed and having significant difficulty remaining in HIV care. This will be provided to individuals with pre-specified criteria associated with low likelihood of re-engaging in care. Individuals in the contingency management sub-group will be offered $20 gift cards if they complete an initial primary care visit, $20 gift cards if they have recommended routine labs drawn and a bonus of $60 gift cards (total $100) if they achieve virologic suppression within 90 days of re-linking to care. Navigators will be responsible for handing out cards as well as ensuring individuals who are given cards follow-through with visits and labs prior to receiving the cards.

Web Services: Fund will be used to pay for fees associated with hosting on-line tools and information around PrEP.

h.	Contractual	$0
	Total PHFE Direct Costs	$268,515
	Category 1 PrEP Total Direct Costs	$138,504
	Category 2 Data to Care Total Direct Costs	$130,011
i.	Total PHFE Indirect Costs (10.8% of Modified Total Direct Costs)	$28,999
	Category 1 PrEP Indirect Cost	$14,958
	Category 2 Data to Care Indirect Cost	$14,041

Please see attached indirect cost rate agreement for details.

Total PHFE Costs	$297,514
Category 1 PrEP Total Cost	$153,462
Category 2 Data to Care Total Cost	$144,052

2. Name of Contractor: **Community Based Organization POL Subcontracts.**

Method of Selection: We will conduct a request for proposal (RFP) process through the City and County of San Francisco. An RFP review will develop criteria and a scoring sheet for the selection of the two community agencies.

Period of Performance: 04/1/2016 - 09/29/2016 with renewals for subsequent years.

Scope of Work: To implement a community level intervention where respected community members are recruited and trained on HIV risk reduction strategies specifically focused on PrEP. These leaders will engage their friends and community in conversations designed to understand PrEP as a prevention tool and ultimately to reduce risk.

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

Itemized budget and justification: We have budgeted $145,000 for this activity. Two agencies will be selected and awarded $72,500 each. An itemized budget for the selected agencies will be submitted for approval once RFP process is complete for CDC approval.

Total Community Based Organization POL Contracts	$145,000
Category 1 PrEP Total Cost	$145,000
Category 2 Data to Care Total Cost	$0

3. Name of Contractor: **Consilience Software, Maven Communicable Disease Surveillance and Management Solution**

Method of Selection: We are currently working with Consilience Software. Our method of selection was as follows.

The jurisdiction received technical assistance from CDC, National Centers for HIV, Hepatitis, STDs, and TB Prevention (NCHHSTP) Informatics Office. The CDC informatics staff assisted the jurisdiction in conducting a marketplace assessment. Based on gathered information, the CDC informatics team came up with a list of nine possible vendors; of these, three met the health department leadership criteria and offered the most functionality.

The three vendors were then invited to San Francisco and gave a one-day demonstration.

Upon review of the systems, all SMEs felt that Consilience (MAVEN) provided the best flexibility to meet our local needs as well as the best opportunity to train DPH staff in the maintenance and upkeep of the system, lessening our dependence on the vendor over time.

Period of Performance: 09/30/2015 - 09/29/2016

Scope of Work: Consilience Software will provide, as needed system development related to enhancements of the PHNIX system. These enhancements may include custom java coding, or specialized functionality that cannot be developed by SFDPH or other contractual staff.

Method of Accountability: DPH staff develops and monitors contract to ensure objectives and deliverables are met.

Itemized budget and justification: An itemized budget will be developed by Consilience and the Informatics team not to exceed $25,000 once the project is started and needs are determined. A detailed budget will be provided to CDC for approval after those meetings occur.

Total Consilience Contract	$25,000
Category 1 PrEP Total Cost	$0
Category 2 Data To Care Total Cost	$25,000

4. Name of Contractor: **Better World Advertising**

Method of Selection: Better World Advertising was selected through a Request for Qualifications (RFQ 22-2013) process held in 2013 by the SFDPH Contracts Unit

Period of Performance: 09/30/2015 - 09/29/2016

Scope of Work: To conduct a social marketing campaign to increase the uptake of PrEP in the target population. Final scope of work will be developed based on the assessment conducted during the first six months of the project, and current formative evaluation funded through local funds, however we expect activities to include developing the social marketing strategy, implementing the campaign, producing materials and purchasing any necessary media space.

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

Itemized budget and justification: We have budgeted a maximum of $150,000 for this campaign. Once the final scope of work is developed, Better Word Advertising will submit their budget and it will be sent to CDC for approval.

	TOTAL DIRECT COSTS:	**$2,590,801**
	TOTAL Category 1 PrEP DIRECT COSTS	**$1,737,864**
	TOTAL Category 2 Data to Care DIRECT COSTS	**$852,937**
I.	**INDIRECT COSTS** (24.03% of total salaries)	**$308,112**
	Please see attached indirect cost memo for details.	
	TOTAL Category 1 PrEP INDIRECT COSTS	**$203,145**
	TOTAL Category 2 Data to Care INDIRECT COSTS	**$104,967**
	TOTAL BUDGET:	**$2,898,913**
	TOTAL Category 1 PrEP BUDGET (66.96% of Budget)	**$1,941,009**
	TOTAL Category 2 Data to Care BUDGET (33.04% of Budget)	**$957,904**

Notice of Award

COOPERATIVE AGREEMENTS **Issue Date:** 09/02/2015
Department of Health and Human Services
Centers for Disease Control and Prevention
NATIONAL CENTER FOR HIV, VIRAL HEPATITIS, STDS AND TB PREVENTION

Grant Number: 1U62PS005027-01
FAIN: U62PS005027

Principal Investigator(s):
Tomas Aragon

Project Title: SAN FRANCISCO PREP AND DATA TO CARE DEMONSTRATION PROJECTS

Christine Siador
Deputy Director, Population Health Division
San Francisco Department of Public Health
101 Grove Street
Room 408
San Francisco, CA 94102

Budget Period: 09/30/2015 – 09/29/2016
Project Period: 09/30/2015 – 09/29/2018

Dear Business Official:

The Centers for Disease Control and Prevention hereby awards a grant in the amount of $2,898,913 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH in support of the above referenced project. This award is pursuant to the authority of 307,317K2 PHSA,42USC241,247BK2,PL108 and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

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

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

Sincerely yours,

Arthur Lusby
Grants Management Officer
Centers for Disease Control and Prevention

Additional information follows

SECTION I – AWARD DATA – 1U62PS005027-01

Award Calculation (U.S. Dollars)	
Salaries and Wages	$1,282,196
Fringe Benefits	$538,523
Personnel Costs (Subtotal)	$1,820,719
Supplies	$32,400
Travel Costs	$12,860
Other Costs	$107,308
Consortium/Contractual Cost	$617,514
Federal Direct Costs	$2,590,801
Federal F&A Costs	$308,112
Approved Budget	$2,898,913
Federal Share	$2,898,913
TOTAL FEDERAL AWARD AMOUNT	$2,898,913
AMOUNT OF THIS ACTION (FEDERAL SHARE)	$2,898,913

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

02 $2,898,913

Fiscal Information:

CFDA Number:	93.940
EIN:	1946000417A8
Document Number:	PS15005027

IC	CAN	2015	2016
PS	93903PS	$2,898,913	$2,898,913

SUMMARY TOTALS FOR ALL YEARS		
YR	THIS AWARD	CUMULATIVE TOTALS
1	$2,898,913	$2,898,913
2	$2,898,913	$2,898,913

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

CDC Administrative Data:
PCC: / OC: 4151 / Processed: ERAAPPS 09/02/2015

SECTION II – PAYMENT/HOTLINE INFORMATION – 1U62PS005027-01

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

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

SECTION III – TERMS AND CONDITIONS – 1U62PS005027-01

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

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

This award has been assigned the Federal Award Identification Number (FAIN) U62PS005027. Recipients must document the assigned FAIN on each consortium/subaward issued under this award.

Treatment of Program Income:
Additional Costs

SECTION IV – PS Special Terms and Conditions – 1U62PS005027-01

Funding Opportunity Announcement (FOA) Number: PS15-1506
Award Number: 1 U62 PS 005027 - 01
Award Type: Cooperative Agreement
Applicable Regulations: 45 Code of Federal Regulations (CFR) Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards

45 CFR Part 75 supersedes regulations at 45 CFR Part 74 and Part 92

AWARD INFORMATION

Incorporation: The Centers for Disease Control and Prevention (CDC) hereby incorporates Funding Opportunity Announcement number PS15-1506, entitled "Health Department Demonstration Projects to Reduce HIV Infections and Improve Engagement in HIV Medical Care among Men Who Have Sex with Men (MSM) and Transgender Persons", and application dated May 30, 2015, as may be amended, which are hereby made a part of this Non-Research award hereinafter referred to as the Notice of Award (NoA). The Department of Health and Human Services (HHS) grant recipients must comply with all terms and conditions outlined in their NoA, including grants policy terms and conditions contained in applicable HHS Grants Policy Statements, and requirements imposed by program statutes and regulations, Executive Orders, and HHS grant administration regulations, as applicable; as well as any requirements or limitations in any applicable appropriations acts. The term grant is used throughout this notice and includes cooperative agreements.

Note: In the event that any requirement in this Notice of Award, the Funding Opportunity Announcement, the HHS GPS, 45 CFR Part 75, or applicable statutes/appropriations acts conflict, then statutes and regulations take precedence.

Approved Funding: Funding in the amount of **$ 2,898,913** is approved for the Year 2015 budget period, which is **September 30, 2015** through **September 29, 2016**. All future year funding will be based on satisfactory programmatic progress and the availability of funds. Category distribution is below:

Category 1: $1,941,009
Category 2: $ 957,904

Note: Refer to the Payment Information section for draw down and Payment Management System (PMS) subaccount information.

Award Funding: Not funded by the Prevention and Public Health Fund

Objective/Technical Review Statement Response Requirement: The review comments on the strengths and weaknesses of the proposal are provided as part of this award. A response to the weaknesses in these statements must be submitted to and approved, in writing, by the Grants Management Specialist/Grants Management Officer (GMS/GMO) noted in the Staff Contacts section of this NoA, no later than 30 days from the budget period start date.Failure to submit the required information by the due date, **October 30, 2015**, will cause delay in programmatic progress and will adversely affect the future funding of this project.

Budget Revision Requirement: By **October 30, 2015** the grantee must submit a revised budget with a narrative justification and work plan. Failure to submit the required information in a timely manner may adversely affect the future funding of this project. If the information cannot be provided by the due date, you are required to contact the GMS/GMO identified in the Staff Contacts section of this notice before the due date.

Program Income: Any program income generated under this grant or cooperative agreement will be used in accordance with the Addition alternative.

Addition alternative: Under this alternative, program income is added to the funds committed to the project/program and is used to further eligible project/program objectives.
Note: The disposition of program income must have written prior approval from the GMO.

FUNDING RESTRICTIONS AND LIMITATIONS

Indirect Costs: Administrative Restriction(s): Indirect costs in the amount of $308,112 is restricted and cannot be spent until a current indirect cost rate agreement reflecting the proposed rate for the period 7/1/2015 through 5/31/2016 is submitted to and approved, in writing, by the Grants Management Officer. If the information is not provided by the end of the budget period, the above amount must be reported on the Federal Financial Report as unobligated funds. To have indirect costs approved for this grant, submit an approved indirect cost rate agreement to the grants management specialist no later than **October 30, 2015**.

Cost Limitations as Stated in the Consolidated and Further Continuing Appropriations Act, 2015 (Items A through E)

A. Cap on Salaries (Div. G, Title II, Sec. 203): None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.

Note: The salary rate limitation does not restrict the salary that an organization may pay an individual working under an HHS contract or order; it merely limits the portion of that salary that may be paid with Federal funds.

B. Gun Control Prohibition (Div. G, Title II, Sec. 217): None of the funds made available in this title may be used, in whole or in part, to advocate or promote gun control.

C. Lobbying Restrictions (Div. G, Title V, Sec. 503):

- 503(a): No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation of the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government itself.
- 503 (b): No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or

any State government, State legislature or local legislature or legislative body, other than normal and recognized executive legislative relationships or participation by an agency or officer of an State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

- 503(c): The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale of marketing, including but not limited to the advocacy or promotion of gun control.

For additional information, see Additional Requirement 12 at http://www.cdc.gov/grants/additionalrequirements/index.html and Anti Lobbying Restrictions for CDC Grantees at http://www.cdc.gov/grants/documents/Anti-Lobbying_Restrictions_for_CDC_Grantees_July_2012.pdf

D. Needle Exchange (Div. G, Title V, Sec. 521): Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

E. Blocking access to pornography (Div. G, Title V, Sec. 526): (a) None of the funds made available in this Act may be used to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography; (b) Nothing in subsection (a) shall limit the use of funds necessary for any Federal, State, tribal, or local law enforcement agency or any other entity carrying out criminal investigations, prosecution, or adjudication activities.

Rent or Space Costs: Grantees are responsible for ensuring that all costs included in this proposal to establish billing or final indirect cost rates are allowable in accordance with the requirements of the Federal award(s) to which they apply, including 45 CFR Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. The grantee also has a responsibility to ensure sub-recipients expend funds in compliance with applicable federal laws and regulations. Furthermore, it is the responsibility of the grantee to ensure rent is a legitimate direct cost line item, which the grantee has supported in current and/or prior projects and these same costs have been treated as indirect costs that have not been claimed as direct costs. If rent is claimed as direct cost, the grantee must provide a narrative justification, which describes their prescribed policy to include the effective date to the assigned Grants Management Specialist (GMS) identified in the CDC Contacts for this award.

Trafficking in Persons: This award is subject to the requirements of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. Part 7104(g)).

Cancel Year: 31 U.S.C. Part 1552(a) Procedure for Appropriation Accounts Available for Definite Periods states the following, On September 30th of the 5th fiscal year after the period of availability for obligation of a fixed appropriation account ends, the account shall be closed and any remaining balances (whether obligated or unobligated) in the account shall be canceled and thereafter shall not be available for obligation or expenditure for any purpose. An example is provided below:

Fiscal Year (FY) 2015 funds will expire September 30, 2019. All FY 2015 funds should be drawn down and reported to Payment Management Services (PMS) prior to September 30, 2019. After this date, corrections or cash requests will not be permitted.

REPORTING REQUIREMENTS

Annual Federal Financial Report (FFR, SF-425): The Annual Federal Financial Report (FFR) SF-425 is required and must be submitted through eRA Commons no later than 90 days after the end of the calendar quarter in which the budget period ends. The FFR for this budget period is due to the GMS/GMO by December 30, 2016. Reporting timeframe is September 30, 2015 through September 29, 2016.

The FFR should only include those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds and may not reflect any unliquidated obligations. There must be no discrepancies between the final FFR expenditure data and the Payment Management System's (PMS) cash transaction data. All Federal reporting in PMS is unchanged

Failure to submit the required information in a timely manner may adversely affect the future funding of this project. If the information cannot be provided by the due date, the grantee is required to contact the Grants Officer listed in the contacts section of this notice before the due date.

FFR (SF-425) Instructions for CDC Grantees are available at http://grants.nih.gov/grants/forms.htm. For further information, contact GrantsInfo@nih.gov. Additional resources concerning the eFSR/FFR system, including a User Guide and an on-line demonstration, can be found on the eRA Commons Support Page: http://grants.nih.gov/support/.

Performance Reporting: The Annual Performance Report is due no later than 120 days prior to the end of the budget period, **April 1, 2016,** and serves as the continuing application. This report should include the information specified in the FOA.

Audit Requirement: An organization that expends $750,000 or more in a fiscal year in Federal awards shall have a single or program-specific audit conducted for that year in accordance with the provisions of 45 CFR Part 75. The audit period is an organization's fiscal year. The audit must be completed along with a data collection form (SF-SAC), and the reporting package shall be submitted within the earlier of 30 days after receipt of the auditor's report(s), or nine (9) months after the end of the audit period. The audit report must be sent to:

Federal Audit Clearing House Internet Data Entry System
Electronic Submission:
https://harvester.census.gov/facides/(S(0vkw1zaelyzjipnahocga5i0))/account/login.aspx

AND

Procurement & Grants Office, Risk Management & Compliance Activity
Electronic Copy to:PGO.Audit.Resolution@cdc.gov

After receipt of the audit report, CDC will resolve findings by issuing Final Determination Letters.

Audit requirements for Subrecipients to whom 45 CFR 75 Subpart F applies: The grantee must ensure that the subrecipients receiving CDC funds also meet these requirements. The grantee must also ensure to take appropriate corrective action within six months after receipt of the subrecipient audit report in instances of non-compliance with applicable Federal law and regulations (45 CFR 75 Subpart F and HHS Grants Policy Statement). The grantee may consider whether subrecipient audits necessitate adjustment of the grantee's own accounting records. If a subrecipient is not required to have a program-specific audit, the grantee is still required to perform adequate monitoring of subrecipient activities. The grantee shall require each subrecipient to permit the independent auditor access to the subrecipient's records and financial statements. The grantee must include this requirement in all subrecipient contracts.

Note: The standards set forth in 45 CFR Part 75 Subpart F will apply to audits of fiscal years beginning on or after December 26, 2014.

Federal Funding Accountability and Transparency Act (FFATA):
In accordance with 2 CFR Chapter 1, Part 170 Reporting Sub-Award And Executive Compensation Information, Prime Awardees awarded a federal grant are required to file a FFATA sub-award report by the end of the month following the month in which the prime awardee awards any sub-grant equal to or greater than $25,000.

Pursuant to 45 CFR Part 75, §75.502, a grant sub-award includes the provision of any commodities (food and non-food) to the sub-recipient where the sub-recipient is required to abide by terms and conditions regarding the use or future administration of those goods. If the sub-awardee merely consumes or utilizes the goods, the commodities are not in and of themselves considered sub-awards.

2 CFR Part 170: http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title02/2cfr170_main_02.tpl

FFATA: www.fsrs.gov.

Reporting of First-Tier Sub-awards
Applicability: Unless you are exempt (gross income from all sources reported in last tax return is under $300,000), you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5) for a sub-award to an entity.

Reporting: Report each obligating action of this award term to www.fsrs.gov. For sub-award information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010). You must report the information about each obligating action that the submission instructions posted at www.fsrs.govspecify.

Total Compensation of Recipient Executives: You must report total compensation for each of your five most highly compensated executives for the preceding completed fiscal year, if:

- The total Federal funding authorized to date under this award is $25,000 or more;
- In the preceding fiscal year, you received—
    - 80 percent or more of your annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR Part 170.320 (and sub-awards); and
    - $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR Part 170.320 (and sub-awards); and
    - The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. Part 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm?explorer.event=true).

Report executive total compensation as part of your registration profile at http://www.sam.gov. Reports should be made at the end of the month following the month in which this award is made and annually thereafter.

Total Compensation of Sub-recipient Executives:Unless you are exempt (gross income from all sources reported in last tax return is under $300,000), for each first-tier sub-recipient under this award, you must report the names and total compensation of each of the sub-recipient's five most highly compensated executives for the sub-recipient's preceding completed fiscal year, if:

- In the sub-recipient's preceding fiscal year, the sub-recipient received—
    - 80 percent or more of its annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR Part 170.320 (and sub-awards); and
    - $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and sub-awards); and
    - The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. Part 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to

the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm).

You must report sub-recipient executive total compensation to the grantee by the end of the month following the month during which you make the sub-award. For example, if a sub-award is obligated on any date during the month of October of a given year (i.e., between October 1st and 31st), you must report any required compensation information of the sub-recipient by November 30th of that year.

Definitions:

- Entity means all of the following, as defined in 2 CFR Part 25 (Appendix A, Paragraph(C)(3)):
  - Governmental organization, which is a State, local government, or Indian tribe;
  - Foreign public entity;
  - Domestic or foreign non-profit organization;
  - Domestic or foreign for-profit organization;
  - Federal agency, but only as a sub-recipient under an award or sub-award to a non-Federal entity.

- Executive means officers, managing partners, or any other employees in management positions.

- Sub-award: a legal instrument to provide support to an eligible sub-recipient for the performance of any portion of the substantive project or program for which the grantee received this award. The term does not include the grantees procurement of property and services needed to carry out the project or program (for further explanation, see 45 CFR Part 75). A sub-award may be provided through any legal agreement, including an agreement that the grantee or a sub-recipient considers a contract.

- Sub-recipient means an entity that receives a sub-award from you (the grantee) under this award; and is accountable to the grantee for the use of the Federal funds provided by the sub-award.

- Total compensation means the cash and non-cash dollar value earned by the executive during the grantee's or sub-recipient's preceding fiscal year and includes the following (for more information see 17 CFR Part 229.402(c)(2)):
  - Salary and bonus
  - Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
  - Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.
  - Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.
  - Above-market earnings on deferred compensation which is not tax-qualified.
  - Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000.

GENERAL REQUIREMENTS

Travel Cost: In accordance with HHS Grants Policy Statement, travel costs are only allowable where such travel will provide direct benefit to the project or program. There must be a direct benefit imparted on behalf of the traveler as it applies to the approved activities of the NoA. To prevent disallowance of cost, the grantee is responsible for ensuring that only allowable travel reimbursements are applied in accordance with their organization's established travel policies and procedures. Grantees approved policies must meet the requirements of 45 CFR Part 75, as applicable.

Food and Meals: Costs associated with food or meals are allowable when consistent with applicable federal regulations and HHS policies and guidance, which can be found at http://www.hhs.gov/asfr/ogapa/acquisition/effspendpol_memo.html. In addition, costs must be proposed in accordance with grantee approved policies and a determination of reasonableness has been performed by the grantees. Grantee approved policies must meet the requirements of 45 CFR Part 75, as applicable.

HIV Program Review Panel Requirement: All written materials, audiovisual materials, pictorials, questionnaires, survey instruments, websites, educational curricula and other relevant program materials must be reviewed and approved by an established program review panel. A list of reviewed materials and approval dates must be submitted to the CDC Grants Management Specialist identified in the CDC Roles and Responsibilities section of this NoA.

Prior Approval: All requests, which require prior approval, must bear the signature of an authorized official of the business office of the grantee organization as well as the principal investigator or program or project director named on this NoA. The grantee must submit these requests by **June 1, 2016** or no later than 120 days prior to this budget period's end date. Any requests received that reflect only one signature will be returned to the grantee unprocessed. Additionally, any requests involving funding issues must include an itemized budget and a narrative justification of the request.

The following types of requests require prior approval.

- Use of unobligated funds from prior budget period (Carryover)
- Lift funding restriction, withholding, or disallowance
- Redirection of funds
- Change in scope
- Implement a new activity or enter into a sub-award that is not specified in the approved budget
- Apply for supplemental funds
- Change in key personnel
- Extensions
- Conferences or meetings that were not specified in the approved budget

Templates for prior approval requests can be found at:
http://www.cdc.gov/grants/alreadyhavegrant/priorapprovalrequests.html

Key Personnel: In accordance with 45 CFR Part 75.308, CDC grantees must obtain prior approval from CDC for (1) change in the project director/principal investigator, business official, authorized organizational representative or other key persons specified in the FOA, application or award document; and (2) the disengagement from the project for more than three months, or a 25 percent reduction in time devoted to the project, by the approved project director or principal investigator.

Inventions: Acceptance of grant funds obligates grantees to comply with the standard patent rights clause in 37 CFR Part 401.14.

Publications: Publications, journal articles, etc. produced under a CDC grant support project must bear an acknowledgment and disclaimer, as appropriate, for example:

This publication (journal article, etc.) was supported by the Grant or Cooperative Agreement Number, **ENTER TEXT**, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

Acknowledgment Of Federal Support: When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all awardees receiving Federal funds, including and not limited to State and local governments and grantees of Federal research grants, shall clearly state:

- percentage of the total costs of the program or project which will be financed with Federal money
- dollar amount of Federal funds for the project or program, and
- percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.

Copyright Interests Provision: This provision is intended to ensure that the public has access to the results and accomplishments of public health activities funded by CDC. Pursuant to applicable grant regulations and CDC's Public Access Policy, Recipient agrees to submit into the National Institutes of Health (NIH) Manuscript Submission (NIHMS) system an electronic version of the final, peer-reviewed manuscript of any such work developed under this award upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. Also at the time of submission, Recipient and/or the Recipient's submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Recipient and/or Recipient's submitting author must also post the manuscript through PMC within twelve (12) months of the publisher's official date of final publication; however the author is strongly encouraged to make the subject manuscript available as soon as possible. The recipient must obtain prior approval from the CDC for any exception to this provision.

The author's final, peer-reviewed manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Recipient and its submitting authors working under this award are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this provision and the license reserved by CDC. The manuscript will be hosted in both PMC and the CDC Stacks institutional repository system. In progress reports for this award, recipient must identify publications subject to the CDC Public Access Policy by using the applicable NIHMS identification number for up to three (3) months after the publication date and the PubMed Central identification number (PMCID) thereafter.

Disclaimer for Conference/Meeting/Seminar Materials: Disclaimers for conferences/meetings, etc. and/or publications: If a conference/meeting/seminar is funded by a grant, cooperative agreement, sub-grant and/or a contract the grantee must include the following statement on conference materials, including promotional materials, agenda, and internet sites:

Funding for this conference was made possible (in part) by the Centers for Disease Control and Prevention. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Logo Use for Conference and Other Materials: Neither the Department of Health and Human Services (HHS) nor the CDC logo may be displayed if such display would cause confusion as to the funding source or give false appearance of Government endorsement. Use of the HHS name or logo is governed by U.S.C. Part 1320b-10, which prohibits misuse of the HHS name and emblem in written communication. A non-federal entity is unauthorized to use the HHS name or logo governed by U.S.C. Part 1320b-10. The appropriate use of the HHS logo is subject to review and approval of the HHS Office of the Assistant Secretary for Public Affairs (OASPA). Moreover, the HHS Office of the Inspector General has authority to impose civil monetary penalties for violations (42 CFR Part 1003). Accordingly, neither the HHS nor the CDC logo can be used by the grantee without the express, written consent of either the CDC Project Officer or the CDC Grants Management Officer. It is the responsibility of the grantee to request consent for use of the logo in sufficient detail to ensure a complete depiction and disclosure of all uses of the Government logos. In all cases for utilization of Government logos, the grantee must ensure written consent is received from the Project Officer and/or the Grants Management Officer.

Equipment and Products: To the greatest extent practicable, all equipment and products purchased with CDC funds should be American-made. CDC defines equipment as tangible non-expendable personal property (including exempt property) charged directly to an award having a useful life of more than one year AND an acquisition cost of $5,000 or more per unit. However, consistent with grantee policy, a lower threshold may be established. Please provide the

information to the Grants Management Officer to establish a lower equipment threshold to reflect your organization's policy.

The grantee may use its own property management standards and procedures, provided it observes provisions in applicable grant regulations found at 45 CFR Part 75.

Federal Information Security Management Act (FISMA): All information systems, electronic or hard copy, that contain federal data must be protected from unauthorized access. This standard also applies to information associated with CDC grants. Congress and the OMB have instituted laws, policies and directives that govern the creation and implementation of federal information security practices that pertain specifically to grants and contracts. The current regulations are pursuant to the Federal Information Security Management Act (FISMA), Title III of the E-Government Act of 2002, PL 107-347.

FISMA applies to CDC grantees only when grantees collect, store, process, transmit or use information on behalf of HHS or any of its component organizations. In all other cases, FISMA is not applicable to recipients of grants, including cooperative agreements. Under FISMA, the grantee retains the original data and intellectual property, and is responsible for the security of these data, subject to all applicable laws protecting security, privacy, and research. If/When information collected by a grantee is provided to HHS, responsibility for the protection of the HHS copy of the information is transferred to HHS and it becomes the agency's responsibility to protect that information and any derivative copies as required by FISMA. For the full text of the requirements under Federal Information Security Management Act (FISMA), Title III of the E-Government Act of 2002 Pub. L. No. 107-347, please review the following website:
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_cong_public_laws&docid=f:publ347.107.pdf

Pilot Program for Enhancement of Contractor Employee Whistleblower Protections: Grantees are hereby given notice that the 48 CFR section 3.908, implementing section 828, entitled "Pilot Program for Enhancement of Contractor Employee Whistleblower Protections," of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013 (Pub. L. 112-239, enacted January 2, 2013), applies to this award.

Federal Acquisition Regulations
As promulgated in the Federal Register, the relevant portions of 48 CFR section 3.908 read as follows (note that use of the term "contract," "contractor," "subcontract," or "subcontractor" for the purpose of this term and condition, should be read as "grant," "grantee," "subgrant," or "subgrantee"):

3.908 Pilot program for enhancement of contractor employee whistleblower protections.

3.908-1 Scope of section.
(a) This section implements 41 U.S.C. 4712.

(b) This section does not apply to-
(1) DoD, NASA, and the Coast Guard; or
(2) Any element of the intelligence community, as defined in section 3(4) of the National Security Act of 1947 (50 U.S.C. 3003(4)). This section does not apply to any disclosure made by an employee of a contractor or subcontractor of an element of the intelligence community if such disclosure-
(i) Relates to an activity of an element of the intelligence community; or
(ii) Was discovered during contract or subcontract services provided to an element of the intelligence community.

3.908-2 Definitions.
As used in this section-
"Abuse of authority" means an arbitrary and capricious exercise of authority that is inconsistent with the mission of the executive agency concerned or the successful performance of a contract of such agency.

"Inspector General" means an Inspector General appointed under the Inspector General Act of 1978 and any Inspector General that receives funding from, or has oversight over contracts awarded for, or on behalf of, the executive agency concerned.

3.908-3 Policy.
(a) Contractors and subcontractors are prohibited from discharging, demoting, or otherwise discriminating against an employee as a reprisal for disclosing, to any of the entities listed at paragraph (b) of this subsection, information that the employee reasonably believes is evidence of gross mismanagement of a Federal contract, a gross waste of Federal funds, an abuse of authority relating to a Federal contract, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a Federal contract (including the competition for or negotiation of a contract). A reprisal is prohibited even if it is undertaken at the request of an executive branch official, unless the request takes the form of a non-discretionary directive and is within the authority of the executive branch official making the request.

(b) Entities to whom disclosure may be made.
(1) A Member of Congress or a representative of a committee of Congress.
(2) An Inspector General.
(3) The Government Accountability Office.
(4) A Federal employee responsible for contract oversight or management at the relevant agency.
(5) An authorized official of the Department of Justice or other law enforcement agency.
(6) A court or grand jury.
(7) A management official or other employee of the contractor or subcontractor who has the responsibility to investigate, discover, or address misconduct.

(c) An employee who initiates or provides evidence of contractor or subcontractor misconduct in any judicial or administrative proceeding relating to waste, fraud, or abuse on a Federal contract shall be deemed to have made a disclosure.

3.908-9 Contract clause.
Contractor Employee Whistleblower Rights and Requirement to Inform Employees of Whistleblower Rights (Sept. 2013)

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

PAYMENT INFORMATION

Automatic Drawdown (Direct/Advance Payments): Payment under this award will be made available through the Department of Health and Human Services (HHS) Payment Management System (PMS). PMS will forward instructions for obtaining payments.

PMS correspondence, mailed through the U.S. Postal Service, should be addressed as follows:

Director, Payment Management Services
P.O. Box 6021
Rockville, MD 20852
Phone Number: (877) 614-5533
Email: PMSSupport@psc.gov
Website: http://www.dpm.psc.gov/help/help.aspx?explorer.event=true

Note: To obtain the contact information of PMS staff within respective Payment Branches refer to the links listed below:

- University and Non-Profit Payment Branch:
http://www.dpm.psc.gov/contacts/dpm_contact_list/univ_nonprofit.aspx?explorer.event=true

- Governmental and Tribal Payment Branch:

http://www.dpm.psc.gov/contacts/governmental_and_tribal.aspx?explorer.event=true

- Cross Servicing Payment Branch:

http://www.dpm.psc.gov/contacts/cross_servicing.aspx?explorer.event=true

If a carrier other than the U.S. Postal Service is used, such as United Parcel Service, Federal Express, or other commercial service, the correspondence should be addressed as follows:

U.S. Department of Health and Human Services
Division of Payment Management
7700 Wisconsin Avenue, Suite 920
Bethesda, MD 20814

To expedite your first payment from this award, attach a copy of the Notice of Grant/Cooperative Agreement to your payment request form.

Payment Management System Subaccount:Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC setup payment subaccounts within the Payment Management System (PMS) for all grant awards.Funds awarded in support of approved activities have been obligated in a newly established subaccount in the PMS, herein identified as the " P Account". A P Account is a subaccount created specifically for the purpose of tracking designated types of funding in the PMS.

All award funds must be tracked and reported separately. Funds must be used in support of approved activities in the FOA and the approved application.

The grant document number and subaccount title (below) must be known in order to draw down funds from this P Account.

Grant Document Number: PS15005027
Subaccount Title: DP151506DEMOTRAMSM15

Acceptance of the Terms of an Award: By drawing or otherwise obtaining funds from the grant Payment Management Services, the grantee acknowledges acceptance of the terms and conditions of the award and is obligated to perform in accordance with the requirements of the award. If the recipient cannot accept the terms, the recipient should notify the Grants Management Officer within thirty (30) days of receipt of this award notice.

Certification Statement: By drawing down funds, the grantee certifies that proper financial management controls and accounting systems, to include personnel policies and procedures, have been established to adequately administer Federal awards and funds drawn down. Recipients must comply with all terms and conditions outlined in their NoA, including grant policy terms and conditions contained in applicable
HHS Grant Policy Statements, and requirements imposed by program statutes and regulations and HHS grants administration regulations, as applicable; as well as any regulations or limitations in any applicable appropriations acts.

CDC ROLES AND RESPONSIBILITIES

Roles and Responsibilities: Grants Management Specialists/Officers (GMO/GMS) and Program/Project Officers (PO) work together to award and manage CDC grants and cooperative agreements. From the pre-planning stage to closeout of an award, grants management and program staff have specific roles and responsibilities for each phase of the grant cycle. The GMS/GMO is responsible for the business management and administrative functions. The PO is responsible for the programmatic, scientific, and/or technical aspects. The purpose of this factsheet is to distinguish between the roles and responsibilities of the GMO/GMS and the PO to provide a description of their respective duties.

Grants Management Officer: The GMO is the federal official responsible for the business and other non-programmatic aspects of grant awards including:

- Determining the appropriate award instrument, i.e.; grant or cooperative agreement
- Determining if an application meets the requirements of the FOA
- Ensuring objective reviews are conducted in an above-the-board manner and according to guidelines set forth in grants policy
- Ensuring grantee compliance with applicable laws, regulations, and policies
- Negotiating awards, including budgets
- Responding to grantee inquiries regarding the business and administrative aspects of an award
- Providing grantees with guidance on the closeout process and administering the closeout of grants
- Receiving and processing reports and prior approval requests such as changes in funding, carryover, budget redirection, or changes to the terms and conditions of an award
- Maintaining the official grant file and program book

The GMO is the only official authorized to obligate federal funds and is responsible for signing the NoA, including revisions to the NoA that change the terms and conditions. The GMO serves as the counterpart to the business officer of the recipient organization.

GMO Contact: See Staff Contacts below for the assigned GMO

Grants Management Specialist: The GMS is the federal staff member responsible for the day-to-day management of grants and cooperative agreements. The GMS is the primary contact of recipients for business and administrative matters pertinent to grant awards. Many of the functions described above are performed by the GMS on behalf of the GMO.

GMS Contact: See Staff Contacts below for the assigned GMS

Program/Project Officer: The PO is the federal official responsible for the programmatic, scientific, and/or technical aspects of grants and cooperative agreements including:

- The development of programs and FOAs to meet the CDC's mission
- Providing technical assistance to applicants in developing their applications e.g. explanation of programmatic requirements, regulations, evaluation criteria, and guidance to applicants on possible linkages with other resources
- Providing technical assistance to grantees in the performance of their project
- Post-award monitoring of grantee performance such as review of progress reports, review of prior approval requests, conducting site visits, and other activities complementary to those of the GMO/GMS

Programmatic Contact:
Cynthia Prather, Project Officer
Centers for Disease Control
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
8 Corporate Boulevard, Mail Stop E-37
Atlanta, Georgia 30329

Telephone: 404-639-5234
Fax: 404-639-1950
Email: cdp2@cdc.gov

STAFF CONTACTS
Grants Management Specialist: Shirley K Byrd
Center for Disease Control and Prevention (CDC)
KOGR Bldg STANF Rm 2057
MS E-15
Atlanta, GA 30341
Email: yuo6@cdc.gov

Grants Management Officer: Arthur Lusby
Centers for Disease Control and Prevention (CDC)
Procurment and Grants Office
2920 Brandywine Road, MS E-15
Atlanta, GA 30341
Email: alusby@cdc.gov **Phone:** (770) 488-2865 **Fax:** 770-488-2868

SPREADSHEET SUMMARY
GRANT NUMBER: 1U62PS005027-01

INSTITUTION: SAN FRANCISCO DEPT OF PUBLIC HEALTH

Budget	Year 1	Year 2
Salaries and Wages	$1,282,196	
Fringe Benefits	$538,523	
Personnel Costs (Subtotal)	$1,820,719	
Supplies	$32,400	
Travel Costs	$12,860	
Other Costs	$107,308	
Consortium/Contractual Cost	$617,514	
TOTAL FEDERAL DC	$2,590,801	$2,590,801
TOTAL FEDERAL F&A	$308,112	$308,112
TOTAL COST	$2,898,913	$2,898,913

CDC-FOA PS15-1506: "Health Department Demonstration Project to reduce HIV Infections and Improve Engagement in HIV Medical Care among Men Who Have Sex with Men (MSM) and Transgender Persons".

Category 1

Summary of Strengths and Weaknesses

Applicant Name: San Francisco Department of Public Health
Amount Requested: $2,898,913
Date of Review: July 7, 2015

RECOMMENDATIONS:

- Address noted weaknesses

OTHER RELEVANT COMMENTS:

- The approaches are evidence based and feasible but without concerted efforts to better understand the target population these approaches will not yield the results expected. Working more closely with CBOs, developing more evaluation questions that seek to understand MSM and Transfemales (TFs) of color's health behaviors not just their health seeking behaviors, and conducting a more in-depth assessment of HIV/AIDS knowledge, attitudes, and beliefs within the target population is a worthwhile investment
- SFDPH should consider financial barriers to accessing PrEP services, such as insurance cost, cost of drugs, transportation cost etc. when targeting this population

1. Approach

Summary of Strengths:

- The approaches are well described and aligns with the NHAS goals. They adequately describe how the proposed approaches will establish and expand and enhance ongoing HIV prevention work. Most of the proposed approaches involve capacity building within SFDPH to implement these activities through the hiring or reassignment of personnel. The approaches are the result of collaboration and alignment with the Getting to Zero Consortium (G2Z) which has the goal of expanding PrEP, providing antiretroviral therapy in the setting of acute HIV infection or upon diagnosis and retention in HIV care.
- The approaches attempt to specifically target MSM and TFs of color through CBOs and other partners familiar with the population as well as through geographic targeting of services.
- The data to PrEP approach describes utilizing STD and hepatitis screening and counseling services to identify, refer, and reach out to high-risk individuals for PrEP services. This approach also proposes utilizing various STD and hepatitis data sources to aid in active surveillance of PrEP.

- Approaches include improving clinical capacity to implement PrEP services through academic detailing, training, and the establishment of Community of Practice (COP). These strategies will empower clinicians to discuss, implement, and address PrEP with patients.
- SFDPH will implement several strategies that involve outreach to affected members of the community. These include material development, placing PrEP ads on dating and hook-up apps, implementing a social media campaign, and using popular opinion leaders to discuss PrEP. SFDPH proposes to help consumers and clinicians navigate PrEP services through PleasePrEPME.org.

Summary of Weaknesses

- Very little is mentioned about investigating and addressing some of the socio-cultural factors related to getting people of color PrEP. Their own data and previous projects highlighted the huge gap in reaching this audience (DAIDS where African Americans and Transfemales (TF) were under-represented in the study cohort 9 African American MSM and 5 TF out of 300 participants. A local TEACH2 PrEP awareness study of 233 in SF found that only 32 (14%) TFs had heard of PrEP and only 1 of those 32 indicated willingness to use PrEP.) It is not clear what attempts SFDPH made or is planning to make to learn about engaging the target population from these projects of the past. Besides the target communities focus, what other steps will be taken to fully engage and ensure they are reaching and impacting the target audience? Popular Opinion Leader (POL) is one good method but with high stakes like this one, more should be done.
- There should be a clear establishment of policies and protocols before outreach.

2. Evaluation and Performance Management

Summary of Strengths:

- The work plan only reflects activities during the first year however, a 3-year logic model was supplied.
- The applicant provided a detailed work plan that describes project activities and plans for monitoring, evaluation, and quality assurance. These activities are feasible, are ready for implementation within 6 months of funding, and include objectives for most activities that are SMART.
- Plans are described to continually revise and update the work plans and 3 year logic model based on findings. The applicant agrees to and has plans to disseminate project findings and lessons learned within the jurisdiction and contribute to dissemination efforts at the local, regional, and national level.
- The applicant proposes mixed methods approach to data collection for the demonstration project.
- There were mixed methods for evaluation presented.
- They plan to disseminate the Continuous Quality Improvement plan for PrEP and Data to Care projects to policymakers, medical providers and members of the target population. This is good to show the community and stakeholders the impact of the work as well as receive feedback on how to improve services.

Summary of Weaknesses:

- The budget and evaluation allocation focuses on hiring personnel. Funds to conduct activities related to evaluation like data collection (e.g., focus groups, recruitment, incentives, translation, etc.) are missing. Further the evaluation is proposed to occur internally which could introduce bias especially if personnel are not familiar with program evaluation standards.

3. Applicant's Organizational Capacity to Implement the Approach

Summary of Strengths:

- The applicant describes the quality of the SFDPH's experience and capacity to implement the PrEP support demonstration project and included a letter of support from the health department ED and local HIV planning group. SFDPH has on staff several personnel who will lead and manage the project but plans to hire others who will work on the project in varying capacities. SFDPH proposes hiring contractors to complete work related to administrative tasks (i.e., hiring, monitoring project progress, etc.), designing and implementing social media campaigns, and designing data/surveillance systems. A description of duties, percentage-of-time commitments, and responsibilities of project personnel was provided. SFDPH also included lines of authority and supervisory capacity through the organizational chart and job titles. SFDPH included plans to ensure that current and new staff members have adequate training to implement proposed activities, including yearly trainings on privacy, data security, and documentation standards. This was also demonstrated by a line item for training in the budget.
- CV and resumes of existing project personnel were included.
- The usage of the already established SF Health Network to continue building upon PrEP Services.
- Letters of support from the local HIV planning group and other partners in support of a PrEP support demonstration project and affirming the health department's ability to hire staff and implement the project as proposed were documented.
- The applicant clearly describe the staffing plan for the project as well as plan to ensure that staff are adequately trained for the project. The Project Director will contribute 0.2 FTE to the grant.

Summary of Weaknesses:

- There are no plans to hire someone with expertise in behavioral health who can help identify and address barriers to accessing the MSM communities of color in SF. Further, none of the positions require persons to have experience with and understand the importance of cultural competency in programming.

4. Budget Comments

- The budget is reasonable, itemized, clearly justified, and consistent with the intended use of the funds. The budget includes itemizations, justifications, scope, and deliverables for consultants and contractors.

- SFDPH budget includes 10% allocation of the overall budget to support local program evaluation personnel.
- SFDPH's proposed budget includes fund for staff to attend a Year 1 orientation meeting and annual meeting in Atlanta. No less than 25% to Category 1 activities.
- The budget and evaluation allocation focuses on hiring personnel. Funds to conduct activities related to evaluation like data collection (e.g., focus groups, recruitment, incentives, translation, etc.) are missing. Further, the evaluation is proposed to occur internally which could introduce bias especially if personnel are not familiar with program evaluation standards.

CDC-FOA PS15-1506: "Health Department Demonstration Project to reduce HIV Infections and Improve Engagement in HIV Medical Care among Men Who Have Sex with Men (MSM) and Transgender Persons".

Category 2

Summary of Strengths and Weaknesses

Applicant Name: San Francisco Department of Public Health
Amount Requested: $2,898,913
Date of Review: July 7, 2015

RECOMMENDATIONS:

- Address noted weaknesses

OTHER RELEVANT COMMENTS:

- Hire behavioral scientists, social epidemiologist, and others who have expertise in behavior change among communities of color. CBOs and non-profit organizations can help advise but that expertise should reside internal to SFDPH.
- The applicants can merge the roles of the LINCs navigators under the PrEP program with those of the Data-to-Care program. There is also a degree of overlap between the roles of the DIS and the Navigators. This needs to be clearly delineated.

1. Approach

Summary of Strengths:

- The approaches are well described and align with the NHAS goals and seem to address access to care, HIV-related disparities and health inequities, and expected outcomes in the city and county of San Francisco. SFDPH adequately described how the proposed approaches will use HIV surveillance data to support continuous, high-quality HIV care as an important tool in HIV medical care. One example is the SFDPH proposes to work with surveillance staff to pilot a process in which HIV surveillance data is used to assess whether a patient is receiving care elsewhere or moved prior to attempting to locate a client. This increases efficiency.
- SFDPH proposes expanding and enhancing current HIV prevention activities by continuing to use the LINCS program to link and re-engage with HIV care using LINCS Navigators. SFDPH will hire attentional navigators and offer contingency management for those that have the most difficult time accessing and staying in care. The applicant also plans to continue with the integration and launch of the PHNIX system. The PHNIX system is an integrated, secure, web-based system for all public health reporting, surveillance, case management, investigation, prevention and control activities for HIV, STDs, TB, hepatitis, and other communicable diseases.

This system will reduce redundancy and increase SFDPH's ability to access data to appropriately identify, engage, survey, and record HIV positive persons from diagnosis to viral suppression.

- The SFDPH plans to engage and coordinate proposed activities with various key stakeholders including G2Z, the SF Health Network, SF General Hospital-based medical providers, community testing agencies, and other SFDPH providers. More specifically, key proposed strategies are to continue using a combined health department/health care provider model to proactively offer data to aid healthcare providers in referring patients to the health department for care, building capacity for HIV workers in HIV clinics, and connecting PHNIX to external clinical data systems.
- SFDPH's detailed plans to prioritize and configure the NIC list through the PHNIX system within year 1 of the grant. This system will also allow for integration of data to care activities with STD and hepatitis screening services in San Francisco. Plans to continue to identify ways to expand and enhance implementation of the demonstration project supporting Data to Care activities by leveraging other resources to support the goals are described and involve assessing activities continually with input from partners.

Summary of Weaknesses

- According to the application, HIV services in the Castro area will be a priority because this area represents the highest proportion of people living with HIV and the highest proportion of people newly diagnosed with HIV, as well as the largest population of MSM. However, beyond this focus none of the activities detail how people of color will be specifically targeted for proposed activities.
- The suggested activities are excellent approaches for general Data to Care initiatives, but the population of greatest need may require additional approaches to change behavior.

2. Evaluation and Performance Management

Summary of Strengths:

- The work plan only reflects activities during the first year however, a 3-year logic model was supplied.
- The applicant provided a detailed work plan that describes project activities and plans for monitoring, evaluation, and quality assurance. These activities are feasible, are ready for implementation within 6 months of funding, and include objectives for most activities that are SMART.
- Plans are described to continually revise and update the work plans and 3 year logic model based on findings. The applicant agrees to and has plans to disseminate project findings and lessons learned within the jurisdiction and contribute to dissemination efforts at the local, regional, and national level.
- The applicant plans to:
  - Evaluate current business processes, data collection practices, and data systems for identifying high-risk clients for PrEP as well as clients for NIC or with unsurpressed viral loads.
  - Maximize and integrate secondary data sources to enhance Data to Care activities.

- Develop predictive analytics, real-time reporting tools, and dashboards to monitor performance on key project indicators.

Summary of Weaknesses:

- None

3. Applicant's Organizational Capacity to Implement the Approach

Summary of Strengths:

- The applicant describes the quality of the SFPHD's experience and capacity to implement the PrEP support demonstration project and included a letter of support from the health department ED and local HIV planning group. SFPHD has on staff several personnel who will lead and manage the project but plans to hire others who will work on the project in varying capacities. SFPHD proposes hiring contractors to complete work related to designing data/surveillance systems. A description of duties, percentage-of-time commitments, and responsibilities of project personnel was provided. SFPHD also included lines of authority and supervisory capacity through the organizational chart and job titles. SFPHD included plans to ensure that current and new staff members have adequate training to implement proposed activities. This was also demonstrated by a line item for training in the budget.
- CV and resumes of existing project personnel were included.
- Experience in HIV surveillance and epidemiology will support this program. According to the CV's, the staff hold a variety of experience in this capacity.
- SFDPH demonstrated an extensive track record of developing and implementing initiatives to promote sexual health and prevent the spread of HIV and other STIs especially for LGBT individuals.
- The SFDPH will leverage on the San Francisco Health Network which has crucial components needed to build a seamless continuum of care for individuals at risk of HIV infection: patient-centered medical homes; comprehensive behavioral health services; acute care and specialty hospital services; and other home- and community-based services.

Summary of Weaknesses:

- There are no plans to hire someone with expertise in behavior health who can help identify and address barriers to accessing the MSM communities of color in SF. Further, none of the positions require persons to have experience with and understand the importance of cultural competency in programming.
- Some of the positions have overlapping roles. It is difficult to delineate completely between the roles of the LINCs Navigators.

4. Budget Comments

- The budget is reasonable, itemized, clearly justified, and consistent with the intended use of the funds. The budget includes itemizations, justifications, scope, and deliverables for consultants and contractors.

- SFDPH budget includes 10% allocation of the overall budget to support local program evaluation personnel.
- SFDPH's proposed budget includes fund for staff to attend a Year 1 orientation meeting and annual meeting in Atlanta. No less than 25% to Category 1 activities.
- The budget and evaluation allocation focuses on hiring personnel. Funds to conduct activities related to evaluation like data collection (i.e., focus groups, recruitment, incentives, translation, etc.) are missing. Further, the evaluation is proposed to occur internally which could introduce bias especially if personnel are not familiar with program evaluation standards.

Table of Contents
San Francisco Department of Public Health
Population Health Division

San Francisco PrEP and Data to Care Demonstration Projects

Health Department Demonstration Projects to Reduce HIV Infections and Improve Engagement in HIV Medical Care among Men Who Have Sex with Men (MSM) and Transgender Persons

CDC-RFA-PS15-1506

Note: CDC Form 0.1113 Assurance of Compliance and the Indirect Cost Rate Agreement are not included in the Table of Contents but are included with the application.

A. BACKGROUND

The City and County of San Francisco (SF) was one of the first and hardest hit epicenters of the HIV epidemic. As of December 31, 2013, SF had 15,901 residents living with HIV – 13% of California's living HIV cases. Nine out of every 10 living HIV cases in SF are among men who have sex with men (MSM). Locally, MSM continue to be disproportionately impacted by HIV, comprising 86% of all HIV cases newly diagnosed in 2013, with 27% of new diagnoses among MSM of color.[1] The good news is that new infections are decreasing, and in 2014 multiple individuals and organizations including the San Francisco Department of Public Health (SFDPH) established the multi-sector, independent **Getting to Zero Consortium (G2Z)**, with the long-term goal of Zero HIV infections, Zero HIV Deaths, and Zero HIV stigma. Its short-term goal is to reduce both HIV infections and HIV deaths by 90% from their current levels by 2020. The G2Z strategic priorities describes a comprehensive approach with three signature initiatives which relate directly to the strategies supported through PS15-1506: 1) PrEP expansion, 2) Provision of antiretroviral therapy in the setting of acute HIV infection or upon diagnosis and 3) Retention in HIV care.

SFDPH has a long history of selecting and supporting scalable, evidence-based interventions to prevent HIV transmission, including partnering with the University of California, San Francisco in 2010 to make SF the first U.S. city to recommend offering antiretroviral treatment as soon as an individual is diagnosed with HIV. The same year, in close collaboration with community and health systems partners, we made a concerted effort to shift resources toward increasing the frequency of HIV testing among MSM, injection drug users (IDU), and transfemales (TF) residents.[2] Approximately 58% of MSM,[3] 38% of IDUs,[4] and 51% of TF[5] in SF have now tested for HIV in the prior six months. Yet there is still much work to be done. Between 300 and 400 people become newly infected with HIV each year in SF, with the majority of these new infections among MSM and TF and the highest incidence rates among MSM and TF of color.[6] The resources from this grant will provide further support to scaling-up our local efforts by addressing critical gaps in PrEP uptake, particularly among persons of color, and enhancing our activities to proactively use data from HIV surveillance to identify HIV-diagnosed individuals not in care, link them to care, and support them to stay in care.

SF has been on the forefront of PrEP research and implementation for over a decade. We participated in early safety studies of tenofovir for PrEP[7,8] and were a site in the global iPrEx trial – a Phase III clinical study that enrolled almost 2500 sexually active MSM and TF in nine cities, including SF.[9] In 2012, SF launched the U.S. PrEP Demonstration Project (DAIDS Protocol ID: #11879). This multisite, open-label demonstration project focused on uptake and adherence to PrEP among MSM and TF. In SF, 300 people were enrolled at SF City Clinic (SFCC), the municipal STD clinic. Uptake was high across all three study sites nationally (SF, Miami, and Washington, DC); in SF 56% of those who were potentially eligible chose to enroll. Of the three sites, we had the highest retention rate, with only 12% of those who enrolled discontinuing PrEP before week 48.[10] While African Americans and TF were no less likely to enroll in the study than whites or MSM, they were under-represented in the study cohort, with only 9 African American MSM and 5 TF among the 300 participants enrolled. These findings reflect the need for increased PrEP education and outreach to MSM of color in SF, and for enhanced efforts to support retention and adherence for this disproportionately affected population.

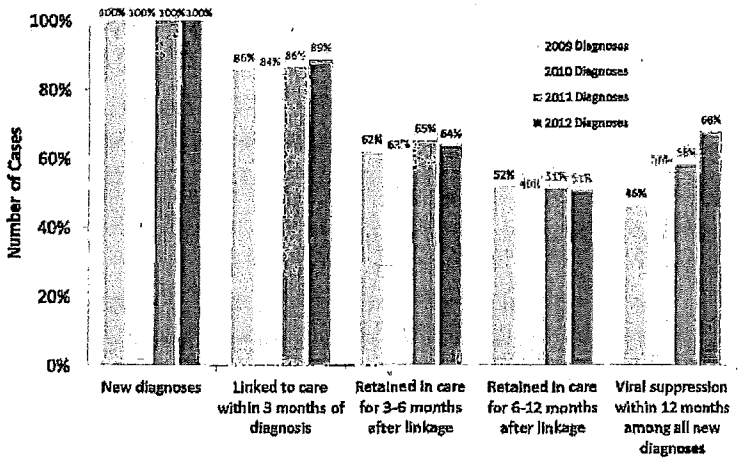
While PrEP awareness appears to be increasing in SF overall – community-based surveys through the National HIV Behavioral Surveillance (NHBS) demonstrated a rise in PrEP awareness from 20% in 2006 to 44% in 2011 – PrEP awareness remains low among key priority populations. In the local TEACH2 survey among 233 TFs in SF in 2013, only 32 (14%) had heard of PrEP, and only one of those 32 was willing to use PrEP for HIV prevention. PrEP use has increased over the last several years, with 5,059 individuals reporting PrEP use in 2013. However, few MSM of color and TF have initiated PrEP in SF. **This proposal will address the urgent need for strategies to increase PrEP knowledge and uptake in these populations, to prevent further disparities in the HIV epidemic.**

Through the DAIDS PrEP demonstration project, we developed screening, counseling, insurance and care navigation, and clinical protocols for PrEP delivery and adapted them for ongoing use in SFCC, which has started over 120 clients on PrEP in the last year. Yet despite these efforts, patients and providers face a number of barriers in PrEP access and delivery. In May 2014 we distributed a 20-question email survey to primary care providers in the SF Bay Area to gather local data on experience with, attitudes towards, and training needs around providing PrEP. In a convenience sample of approximately 101 prescribing clinicians (see Table 1 for demographics of respondents) we found high willingness to prescribe PrEP to patients at ongoing risk of HIV infection (76% overall extremely or highly likely to prescribe). At the same time, many responding clinicians expressed concerns about PrEP, including toxicity, adherence, drug resistance, drug cost, and side effects; 65% wanted training on aspects of PrEP, especially on the operational aspects of PrEP delivery, such as visit frequency, HIV testing, and counseling patients on adherence and sexual risk behavior. Respondents wanted to receive training through multiple methods, including person-to person (95% telephone warmline or face-to-face) or electronic (online course 55%, online document repository of clinical 73% and counseling (63%) guidelines, video vignettes (27%)). This highlighted a high willingness to prescribe, but also significant concerns and training needs, which we will address through this proposal by outreach and education to clinicians by the training methods they prefer, including individual public health detailing, clinical mentoring, mini-workshops, and a repository of on-line resources, such as videos of fictional counseling sessions, webinars, and document libraries. We will also continue to partner with the Centers for Disease Control and Prevention (CDC)-funded PrEP Warmline at the University of California SF (UCSF), located on the SFDPH campus of SF General Hospital (SFGH), whose staff includes some of the members of our team.

Table 1. Provider Survey Demographics (N=101)

Race/ethnicity	White	69%
	African American	27%
	Latino	8%
Median Age		44
Gender	Female	56%
	Male	44%
Length of time in practice	>10 years	53%
	10 years or fewer	47%
Certification	MD/DO	73%
	NP/PA	11%
Specialty	Family medicine	51%
	Internal medicine	26%
	Infectious disease	12%
Experience caring for HIV+ patients	Yes	79%
	No	21%
Insurance taken	Private	49%
	Medi-Cal	90%
	Other public	63%
	Uninsured	68%

Figure 1. SF Continuum of HIV Care, 2009-2012.



When it comes to those who are already HIV-positive, we are also making strides. From 2009-2013, the number of people newly diagnosed with HIV in SF declined from 463 to 359 new diagnoses.[2] Yet, while some improvement has been seen in those years, **many who are diagnosed continue to fall out of care or fail to become virally suppressed**, an indication that ARV medication has not been started or adhered to as needed. (See Figure 1).[1] In recent years, between 84% and 89% of people newly HIV-diagnosed in SF were linked to care within 3 months of diagnoses and in 2012, 68% of people newly diagnosed achieved viral suppression within 12 months (Figure 1). However, our surveillance data shows that African-Americans and Latinos are less likely to have timely linkage to care and viral suppression when compared to Whites.[1]

B.1. APPROACH – CATEGORY 1 (PrEP)

i. Purpose

Funding for Category 1 will enable us to implement high-impact, evidence-based strategies to improve uptake of PrEP among people at substantial risk for HIV in SF, especially MSM of color and TF. Our jurisdiction is keenly aware that Pre-Exposure Prophylaxis (PrEP) is a critical tool to reduce HIV infections among persons at substantial risk of acquiring HIV and optimizing the health outcomes of people living with HIV. The activities detailed below align both with the G2Z strategic priorities and the National HIV/AIDS Strategy (NHAS) goals of reducing new HIV infections, and reducing HIV-related disparities and health inequities.

ii. Outcomes

By the end of the project period, we expect to achieve the following outcomes for Category 1:

SHORT-TERM OUTCOMES:

- Increased capacity of SFDPH to implement PrEP support activities for people at substantial risk of HIV, especially MSM and TF, particularly persons of color (the "target population")
- Increased knowledge and awareness of PrEP for HIV prevention among the target population
- Increased provider knowledge and awareness of PrEP, and training in clinical management of PrEP for HIV prevention among providers
- Increased capacity of SFDPH to integrate services and share and utilize data across HIV, STD, Hepatitis programs, and the SF Health Network to help identify those who can benefit from PrEP, especially the target population

INTERMEDIATE OUTCOMES:

- Establishment of policies, procedures and protocols to implement PrEP support activities for the target population
- Increased number of providers trained to offer PrEP to the target population
- Increased number of PrEP prescriptions for the target population

- Establishment of policies, procedures and protocols to integrate services and share data across the SF Health Network and HIV, STD and Hepatitis programs to help identify those who can benefit from PrEP, especially the target population
- Enhancements to the Public Health Network Information Exchange (PHNIX) information system to support ongoing data-driven decision making around PrEP activities

iii. Strategies and Activities

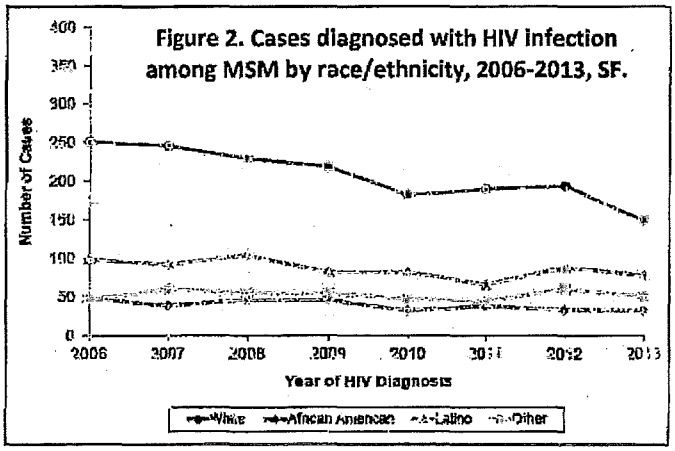
Our proposal details a number of strategies designed to increase PrEP uptake overall and address disparities in PrEP knowledge, access, and uptake, particularly among MSM of color and TF in SF. A core element of these strategies is the establishment of a 1.0 FTE Lead PrEP Coordinator position at SFDPH. The Lead PrEP Coordinator will manage the day-to-day activities of the program and help ensure that each of the activities and staff are functioning with maximum efficiency and effective communication. S/he will be supported by a 1.0 FTE Health Educator who will manage details of protocol development and dissemination to stakeholders.

1. Collaborations

We have a long history of community collaboration with HIV care agencies, HIV advocates, and persons living with HIV/AIDS. For this project, the SFDPH and CDC will work closely with the Getting to Zero Consortium (G2Z). The PrEP activities proposed here arose out of the G2Z strategic planning process and have the full support of the G2Z membership. As always, we will also work closely with dozens of community-based organizations and community clinics, which together create the HIV Prevention and Care Network that is so important to our city. This includes regular leadership and engagement with the HIV Prevention Planning Council and the Ryan White Care Council, both of which are filled with people living with HIV, and community leaders representing agencies serving people living with HIV.

2. Target Populations

MSM (including those who inject drugs) make up 89.0% of people living with HIV in San Francisco[1] despite being only 7.7% of the total population citywide.[11,12] Twenty-seven percent of cases are among MSM of color, and although the overall numbers of cases diagnosed in SF among MSM each year is declining, most of the decrease is seen in white MSM, with diagnoses among MSM of color holding relatively steady as seen in Figure 2.[1] **Even more distressing, per consensus estimates, a full 38% of TF in SF are living with HIV** with a shocking 2.6% becoming infected each year (the incidence rate is 3.88% among TF who inject drugs).[12] <u>For these reasons, we are focusing our PrEP strategies and activities on MSM and TF at high risk for HIV infection, with emphasis on people of color.</u>



3. Activities

Activity 1: Analysis and Further Assessment of Gaps

In the first half of year 1, we plan to conduct a detailed analysis of the data related to barriers to PrEP usage for our target population. This analysis will be conducted by a 1.0 FTE Senior Epidemiologist working within the HIV Surveillance Unit of SFDPH, and will involve a mixed-methods approach: analysis of data in the HIV surveillance, HIV Counseling, Testing, and Referral (CTR), SF Health Network, and STD testing data systems; brief surveys, focus groups, and key informant interviews with members of the target population; and focus groups and key informant interviews with HIV care providers in settings most utilized by the target population for care. The analysis will answer a series of key questions:

1) What are additional barriers to PrEP for our target population?
2) Where are members of our target population currently seeking HIV/primary care?
    a. Where were those newly diagnosed with HIV getting primary care *before* diagnosis?
    b. What proportion of our target population (particularly MSM of color and TF) do not currently have a medical home?
3) What is the optimal and preferred site of PrEP screening and delivery for the priority populations (i.e. primary care, pharmacies, a CBO, municipal STD clinic)?
4) What are barriers to providing PrEP in the settings identified in #3, above?

This analysis is a critical part of our overall strategy, because as stated earlier, we know that in our existing work to increase PrEP uptake in SF, African American MSM and TF have been significantly underrepresented; additionally, of those who *do* enroll, their rates of PrEP retention and adherence are significantly lower than other groups.[13] This illustrates a need for innovative strategies to engage this target population in PrEP and support their adherence to the medications. This requires an enhanced understanding of their particular barriers to PrEP uptake, and exploration of which strategies may be most effective to improve rates of engagement in PrEP within these communities.

Activity 2: Targeted Community Engagement

In the second half of year one, once our barrier analysis (Activity 1) has concluded and a final report is disseminated to project staff and key stakeholders, we will begin outreach for members of the target population who are not already in primary care, or in care but not sure about PrEP as an HIV prevention strategy that could work for them. The exact methods of outreach will be determined by the project staff based on the findings of the assessment; however, we expect that this outreach will involve both a social marketing campaign and the use of Popular Opinion Leaders to reach the target population. In the US PrEP demonstration study, we found that 65% of self-referred clients had heard about PrEP from a friend or sex partner, demonstrating the importance of peer-influence in driving PrEP uptake.[14]

1) **Social Marketing:** DPH has contracted with Better World Advertising (BWA) to conduct "listening sessions" with members of the G2Z Consortium in the summer of 2015 to learn the inventory of current local and national social marketing campaigns to increase PrEP uptake. There are many resources currently in place and BWA will analyze opportunities and needs, as well as identify efficiencies and reduce potential overlap. During the same time period, BWA will also conduct listening sessions with key HIV prevention CBOs in SF; following the listening

sessions, BWA will present the concepts to focus groups of consumers for input and fine-tuning. The expectation is that by the time 15-1506 is awarded, a campaign will already have been planned and funding from this grant will be used to implement the final model.

2) Popular Opinion Leader (POL): In addition to social marketing, our project will draw on a proven strategy for delivering HIV and STD prevention messages to MSM and TF, especially those of color: the Popular Opinion Leader (POL) intervention. POL is a community level intervention in which respected community members are recruited and given training on HIV risk reduction strategies. These leaders then engage their friends in conversations designed to reduce HIV risk while normalizing healthier sexual behaviors.[15] In their 1992 study, Kelly et al demonstrated a 15 – 29% reduction in HIV risk behaviors when trained peer leaders communicated risk reduction recommendations to friends.[16] Among African American men ages 18 – 30, Jones and colleagues demonstrated that a POL intervention specifically adapted for African American MSM significantly increased condom use and decreased both the number of partners for and episodes of unprotected sex. This intervention has been proven effective when adapted for Latinos as well. The *Promotores* program, implemented among young Latino MSM in Texas and California, demonstrated both an increase in HIV/STD knowledge and a reduction in risk behaviors.[17] For our project, we will write an RFP and subcontract $145,000 to CBOs with experience using POL, and the established reputation and relationships with MSM of color and TF. This strategy is in line with the recommendations of the PrEP User Subcommittee of the Getting to Zero Consortium, which has called for the use of PrEP Community Ambassadors to network and provide education in different high-risk communities in San Francisco.

3) Navigation to PrEP: We will then build upon these strategies to improve our ability to educate and directly link members of the target population to PrEP services. Strategies that have been recently recommended by the PrEP User Subcommittee of the Getting to Zero Consortium and/or the SF Transgender Advisory Group will be vetted during the barrier analysis period (Activity 1), and potentially incorporated into our outreach strategies under this proposal. They include:

- PrEP advertisement and navigation using hookup apps such as Grindr, SCRUFF, Hornet, and BarebackRT, with a PrEP Navigator available to answer questions about PrEP to app users
- Increasing the use of PrEP-related Town Halls (presentations at churches, community centers, bars, etc.) and participation in events such as the Gay Pride parade or Castro Street Fair
- PrEP navigation services that are based online, including the *PleasePrEPMe.org* website that provides geolocation of the nearest PrEP clinics, chat-based access to a Navigator to answer questions and provide referrals, and an online database that allows someone to plug in zip code, income, and insurance status to receive information on local providers or benefits.

Activity 3: "Data to PrEP"

Building on the idea of the Data to Care evidence-based intervention (Category 2), we also plan to implement a series of data-based strategies to assist SFDPH identify and reach out to those with the greatest need for PrEP. As part of this activity we will also work to build the capacity of

our Disease Intervention Specialists (DIS) to recognize PrEP eligibility and directly refer members of the target population to settings where they can obtain PrEP.

First, we will use STD surveillance, SF Health Network, Hepatitis, and HIV CTR 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. This will involve an 0.5 FTE Epidemiologist Informatician/Systems Designer to conduct the analysis of data in existing systems, as well as approximately 400 hours of system developer time to develop system functionality within our Public Health Network Information Exchange (PHNIX) data system (Consilience Software), scheduled to be launched within year 1 of this project. This will include the ability to flag individuals who are prime candidates for PrEP and provide their contact information to Navigators who can support them in obtaining PrEP.

Secondly, we recognize that our DIS staff are in an exceptional position to identify and facilitate connections with members of the target population who are strong candidates for PrEP. These staff are trained and employed specifically to reach out to those who are at high risk for or have recently contracted or been exposed to an infectious disease. We plan to build DIS capacity to recognize PrEP eligibility and provide direct information and referrals for PrEP to those at highest risk, through funding 0.5 FTE of a DIS who will function as our PrEP champion. This DIS will do ongoing training and support for their colleagues, and will work with internal data to ensure we are presenting PrEP as a routine part of HIV and syphilis Partner Services.

Once our DIS staff are fully trained, we will combine their skills with enhanced data system functionality to more thoroughly integrate PrEP services into Partner Services and STD testing and treatment efforts. While PrEP is more commonly connected with HIV testing services it is a novel strategy to use data to integrate PrEP services into Partner Services and STD testing. However, individuals with a rectal STD and those who are named in HIV or syphilis Partner Services interviews – if not already HIV-positive – are by definition at high risk for HIV. We plan to use our data systems and our DIS to identify those individuals quickly, and offer not just HIV and STD testing but also a direct connection to PrEP services. Similarly, someone who comes into any public service location for an STD test and has a positive result will also be flagged and rapidly approached by a DIS or other Navigator for linkage to PrEP.

One important and novel component of this activity is our plan to implement procedures for **active surveillance of PrEP.** The PrEP Metrics subcommittee of the Getting to Zero Consortium has recommended the following activities to help us have a clear understand of PrEP use in SF, which we will undertake with this grant, using an epidemiologist to coordinate activities:

1) Regularly pulling data from the electronic medical records of SF Health Network providers, about the number of patients prescribed PrEP, by site.
2) Adding questions about PrEP use to the data collection form for the HIV CTR database, to gather information from people testing for HIV in public counseling and testing sites.
3) Working with pharmacies, starting with Walgreens and Kaiser, to set up systems for regular reporting of PrEP prescriptions to SFDPH.

Activity 4: Building Provider Capacity to Offer PrEP

Finally, we recognize that one of the biggest limiting factors to widespread use of PrEP in SF is not simply interest on the part of the target population, it is their ability to obtain affordable,

accessible, and stigma-free PrEP services. Providers may not understand PrEP, or may be unwilling to prescribe PrEP based on concerns about clinic flow or the inability to offer the regular follow-up care required for maintenance of a PrEP regimen. Some providers may be worried that PrEP might lead to risk compensation or that the medication may cause harmful side effects for their patients. Providers that may *want* to offer PrEP may have limited capacity, and often have competing health issues to address with their patients. We plan to address these barriers and build provider capacity to offer PrEP through a series of 3 strategies:

1) **Developing tools/materials to improve provider knowledge of PrEP:** There are many materials available on the internet, including via the CDC Provider Portal that informs and encourages medical providers to prescribe PrEP. However, there is a shortage of actual practical implementation tools (checklists, protocols, etc.) that help providers actually get a PrEP program off the ground. In the first year of the project, we will conduct in-depth interviews with around a dozen providers, to understand potential barriers to PrEP, and identify what tools and guidelines would be most helpful. We will also conduct an exhaustive search of available materials (including those already developed by Kaiser Permanente and the New York City STD/HIV Prevention Training Center) so as to avoid "reinventing the wheel." We will then take those findings and develop a series of tools adapted for SF clinicians, to encourage the start or support of PrEP programs. To accomplish this, we have budgeted a 0.5 FTE position in the Center for Learning & Innovation during year 1 of this grant; this person will be responsible for development, compilation, and dissemination of these tools. Additionally, as part of the U.S. PrEP Demo Project, the SFCC created a protocol with various tools (counseling worksheets, insurance navigation tips, a visit-by-visit guide to implementing PrEP, etc.) that are useful for a PrEP program based at a municipal STD clinic. These materials will be adapted to other settings, such as private provider's offices, public primary care clinics, or community organizations.

2) **Academic detailing:** Academic detailing involves trained medical professionals providing one-on-one evidence-based outreach to providers with the goal of objectively presenting the latest scientific information on significant and time-sensitive medical interventions to benefit providers who have limited availability to stay independently informed of new scientific findings. It applies the social marketing techniques of pharmaceutical detailing to academic-based education initiatives by using: interactive dialogue, engaging presentations, visually stimulating materials, and accountable behavioral change objectives. This method of education outreach is an effective alternative to the traditional didactic method of CME that is often unable to engage providers to substantiate behavior change. To increase accessibility and effectiveness, academic detailing takes place in providers' own offices at their convenience and encounters typically range from 3-30 minutes. **Academic detailing is associated with statistically significant behavior change** and has been proven to successfully reduce drug costs,[18] scale-up routine HIV testing,[19] increase smoking cessation efforts, and optimize effective prescription of medications by primary care providers.[20]

In October of 2014, the SFDPH initiated a program to detail non-DPH primary care providers in SF on opioid safety and naloxone co-prescription. We developed materials for the intervention, built a list of primary care providers based on a list of providers who prescribed opioids to Medi-Cal patients, and began detailing providers in February of 2015. As of April 2015, this program had resulted in successful detailing of 35 providers. Information is forthcoming about

the impact this detailing intervention had on opiate prescriptions, though literature about the impacts of academic detailing suggests it is likely to demonstrate positive impact.

Our PrEP academic detailing program will include the following elements:

- Adapting New York's "PrEP and PEP Action Pack" for clinicians.[21]
- Hiring of a 1.0 FTE Nurse Practitioner (NP) who will serve as the front-line academic detailer, reaching out to providers. This detailer would be more of a *probe* than the traditional pharmaceutical model of "pushing" a product. While of course s/he would encourage the use of PrEP with patients, in this case the lead detailer would provide information, then report back to the detailing support team if someone is interested but unlikely to begin prescribing PrEP without additional follow-up and technical support to reduce barriers.
- Funding additional 0.5 FTE of an existing NP with detailing experience to support and follow-up with interested providers. Whenever a provider appears interested in PrEP but is concerned about technical issues such as clinic flow or other implementation matters, the lead detailer will refer that provider to the support detailer for follow-up. They will be available to clinicians in person, via phone, or through email as needed to support their use of PrEP on an ongoing basis, until this support is no longer necessary.
- Training and ongoing support of the detail team. Experience has shown that academic detailing is not an easy task, and to be successful it is critical to provide ongoing training, supervision, and support of detailers. Our detailers will be supervised by Dr. Stephanie Cohen, Medical Director SF City Clinic; furthermore, the detailing team will be sent to a formal academic detailing training within the first 3 months of their hiring.

3) <u>Establishment of "Communities of Practice" (CoPs)</u>: In year 1 of the grant, the staff position in the Center for Learning & Innovation dedicated to establishing PrEP tools/materials for providers will devote their remaining 0.5 FTE to recruiting providers to participate in one of a number of CoPs. CoPs will be defined by role (i.e. administrators, test counselors, primary care providers) and by type of service organization (i.e. non-clinical organizations that work closely with the target population such as sociocultural groups, neighborhood organizations, or churches; HIV prevention agencies already providing PrEP services; and health clinics trying to start PrEP programs). All providers can participate, but providers who are diagnosing HIV/STDs among their patients/clients, especially MSM of color and TF, will be identified via surveillance data review and actively invited to join a CoP. Participation in a CoP will involve two benefits: a) access to an online forum for PrEP providers, where clinicians can ask their peers for advice on challenging cases or situations and receive rapid advice or other responses from others in the CoP, and b) Videoconferencing every two months to discuss PrEP implementation issues in depth with other similar providers. Project ECHO demonstrated the value of videoconferencing for hepatitis C providers in New Mexico. In 2009, the Robert Wood Johnson Foundation funded a pilot project to extend this module to Washington State, and videoconferences were added in the area of HIV/AIDS.[22] We currently partner with the Univ. of Washington to use this technology to support health departments in PrEP implementation nationally. This videoconferencing technology only requires a regular computer webcam; ease of implementation facilitates use with a wide variety of providers.

After set up work in the first year, the Health Program Coordinator will work full-time to facilitate and manage these CoPs, including managing logistics, inviting expert presenters, handling technical aspects of videoconferences, and maintaining provider membership in CoPs.

4) Reaching out to Community Service Providers: Finally, we recognize that CBO service providers frequently serve clients at elevated risk for HIV, including MSM of color and TF. For this reason, we have allocated a 1.0 FTE Health Worker to serve as a PrEP Navigator, building and maintaining relationships with community service providers who work well with this target population. These include HIV test counselors, case managers, outreach workers, substance use counselors, and syringe access providers. Similar to the work described in the *Academic Detailing* section, for this activity staff will reach out to these providers to assess their knowledge and willingness to refer for PrEP, and provide education or technical support when needed, to encourage strong PrEP referrals.

B.2. APPROACH – CATEGORY 2 (DATA TO CARE)

i. Purpose

Funding for Category 2 will enable us to fully implement the CDC Data to Care intervention in SF and increase the proportion of HIV-diagnosed MSM and TF in SF who are virally suppressed, especially for people of color. Our jurisdiction is keenly aware that Data to Care is a critical tool to reduce HIV infections among persons at substantial risk of acquiring HIV and optimizing the health outcomes of people living with HIV. The activities detailed below align both with the G2Z strategic priorities and the NHAS goals of reducing new HIV infections, and reducing HIV-related disparities and health inequities.

ii. Outcomes

By the end of the project period, we expect to achieve the following outcomes for Category 2:

SHORT-TERM OUTCOMES:

- Increased capacity of SFDPH to implement Data to Care activities for HIV-diagnosed MSM, TF, and other persons who have HIV but are not virally suppressed or have ongoing risk behavior, who currently are not in HIV medical care (the "target population")
- Increased capacity of SFDPH to conduct outreach to the target population

INTERMEDIATE OUTCOMES:

- Increased capacity of SFDPH to use surveillance, program, and clinical data to accurately identify members of the target population who reside in San Francisco
- Increased capacity of SFDPH to contact members of the target population
- Increased capacity of SFDPH to refer the target population to HIV medical care
- Increased proportion of all HIV-diagnosed MSM and TF who are virally suppressed
- Reduced length of time between identification of the target population and their successful engagement or re-engagement in HIV medical care

iii. Strategies and Activities

In 2011, we developed the Linkage, Integration, Navigation, and Comprehensive Services (LINCS) program, designed to link newly diagnosed people to HIV medical care, and provide

short-term navigation services to previously diagnosed patients who are out of care. LINCS is currently staffed with 1.5 FTE Navigators who work to provide short-term navigation for people living with HIV for up to 90 days, with the goal of linking or re-linking people to care. LINCS clients are identified almost exclusively through provider referral at this time. Overall, this program has been successful: in 2012 and 2013, 315 patients were referred to LINCS. 116 (37%) were located and enrolled in LINCS, and 74% of those were successfully re-linked to care. 3-12 months after case closure, 51% of those who were re-linked to services by LINCS were virally suppressed, compared with only 23% of those who were not re-linked (p=0.007).[23]

We recognize the value in utilizing surveillance data to support continuous, high-quality HIV care. To that end, LINCS is currently working with HIV surveillance staff to pilot a Data to Care process in which prior to attempting to locate the client, HIV surveillance staff assess whether the patient is receiving care elsewhere or has moved using routinely collected HIV surveillance data. For a summary of current Data to Care activities see Table 2 below.

Table 2: SF Data to Care: Current use of HIV Surveillance to support LINCS activities.

Activity	Data Flow
1. Determine if patients testing HIV-positive at SFDPH funded testing sites are new or known cases to prioritize linkage and partner services activities to newly diagnosed patients.	The LINCS program receives names of patients testing HIV-positive at SFDPH funded test sites. HIV Surveillance determines if these HIV-positive patients are new or known cases. Returns information to LINCS.
2. Determine if sex partners named by a newly diagnosed patient are already known to be HIV+ to prioritize partner services for HIV-negative partners.	The LINCS program collects names of sex partners from newly diagnosed index cases. HIV Surveillance determines if these partners are HIV-infected or negative. Returns information to LINCS.
3. Refer patients testing positive in private medical sites to LINCS for linkage and partner services.	HIV Surveillance identifies people testing HIV positive at private medical sites. Returns this information to LINCS.
4. Determine if not-in-care (NIC) clinic patients are receiving care elsewhere or have moved out of SF prior to referral of cases to LINCS or further clinic action.	LINCS provides names of clinic patients who appear to be NIC from their caseload to HIV Surveillance. HIV Surveillance determines if these patients are receiving care elsewhere or have moved.

Using the wealth of available surveillance data to focus and prioritize our efforts on those who need it most will not only increase our efficiency, but it will reduce HIV-related health disparities in SF by increasing the percentage of people who are virally suppressed in the target population.

1. Collaborations

As with Category 1, the San Francisco Getting to Zero Consortium (G2Z) is a major source of support and collaboration for these Category 2 activities. Additionally, within SFDPH, the LINCS Navigation program relies on partnerships with the SF Health Network and SF General Hospital-based medical providers, community testing agencies, and other SFDPH providers to improve patient health by increasing accessibility to HIV primary care, HIV treatment, and relevant services. The HIV care Navigators work with HIV positive patients intensively to help them

engage in primary medical care and connect them to long-term case management and other services through warm referrals and direct handoffs. These existing successful collaborations between SFDPH and the clinical and service organization sites discussed in this application will continue and should help maximize the likelihood of success of this Data to Care project.

2. Target Populations

The SFDPH HIV Surveillance Branch tracks the demographic characteristics, geographic location and care indicators for all people living with HIV and for people newly diagnosed with HIV each year in SF. In addition, SFDPH is an HIV Incidence Surveillance site funded by CDC to calculate an estimate of new HIV infections (as opposed to new diagnoses) each year in SF. Current data indicate that the areas in SF where HIV-infected persons are least likely to be virally suppressed are the Excelsior, Bayview, Outer Mission and the Tenderloin (see Figure 3). Data additionally suggest that in order to address gaps and inequalities in access to HIV care and prevention services, the SFDPH should prioritize services in these same neighborhoods[24] – areas with the highest concentration of Latinos, African Americans, and TF – to decrease disparities in HIV incidence among the sub-populations less likely to be virally suppressed. Furthermore, data from HIV Incidence Surveillance found that the rates of HIV incidence are disproportionately high among MSM compared to the overall incidence rate in the City, and among African Americans and Latinos compared to Whites.[1] This suggests that to prevent the greatest number of new infections, the SFDPH should prioritize HIV prevention services in the Castro, an area with the highest proportion of people living with HIV and the highest proportion of people newly diagnosed with HIV as well as the largest population of MSM (see Figure 4).

Figure 3. Geographic distribution of proportion of living HIV cases diagnosed through 2011 who achieved viral suppression in 2012

Figure 4. Geographic distribution of persons living with HIV, December 2013, SF

For these reasons, as with Category 1 we have decided to focus our Data to Care strategies and activities on MSM and TF at high risk for HIV infection, with emphasis on people of color.

3. Activities

SFDPH is currently preparing for launch of the Public Health Network Information Exchange (PHNIX), an integrated, secure, web-based system for all public health reporting, surveillance, case management, investigation, prevention, and control activities for HIV, STDs, TB, hepatitis, and general communicable disease. Currently, HIV testing, partner services, linkage

and navigation, and surveillance data are collected in separate databases. By the end of 2015, HIV data will be fully integrated into a single, web-based, client-centered information system. By the end of 2016, we expect full integration of HIV data with STD and hepatitis C program and surveillance data.

Activity 1: Prioritization/Configuration of the Not-In-Care (NIC) List

It is currently expected that when PHNIX launches in year 1 of this grant, the HIV module will include integrated information about:

- All HIV surveillance data (formerly pulled directly from eHARS)
- All HIV CTR data (formerly managed via EvaluationWeb)
- All Partner Services data (formerly managed by the STD data system, ISCHTR)
- All HIV care linkage and retention data (formerly managed by ISCHTR)
- All laboratory requisitions and results from the SFDPH Microbiology Lab, including HIV diagnostic tests, CD4 counts and viral loads.

To support the use of Data to Care, we already have experience generating NIC lists directly from eHARS, which we will continue to do for this project until PHNIX has successfully launched. However, once launched, PHNIX will have functionality to produce reports that include:

- People who are >90 days from HIV diagnosis and have not yet received a viral load or CD4
- People who are <90 days from HIV diagnosis and have not yet received a viral load or CD4
- People who lack evidence (in HIV CTR data) of ever being referred to HIV medical care
- Evidence of ARV treatment, from any of the integrated data sources
- Evidence of viral suppression, from any of the integrated data sources

Through this project, we will dedicate epidemiology, informatics, and IT developer resources toward investigating how changes to the NIC list data and formatting will impact intervention effectiveness, identifying process improvements, and making system changes accordingly. We will do this with a 1.0 FTE Epidemiologist/Data to Care Specialist will work closely with the Senior Epidemiologist to determine the optimal priorities for the NIC list data and configuration. For example, it may make sense to enter "risk profile" as part of HIV testing data collection, regardless of the test result. Or, it may make sense to emphasize one particular demographic or service activity to flag an individual for rapid follow-up, or to change the time interval for report generation or definition as "NIC" and eligible for outreach and follow-up. This epidemiologist will also work with a 0.5 FTE Epi Informatician/Systems Designer and PHNIX system developer(s) to examine opportunities to use these data in novel ways, such as confirming care status of HIV-positive individuals named through Partner Services interviews, or HIV-positive individuals who have a detectable viral load *and* are diagnosed with an STD, and targeting education, training, and support services to providers whose clients are at highest risk for falling out of care.

When changes to the PHNIX system are recommended, these changes will be made by the system developer and/or the software developer as needed; approximately additional 300 hours of system developer time and $25,000 for fees to Consilience software (for change requests that cannot be done in-house) are budgeted for this purpose, in year 1.

Activity 2: Linkage and Re-engagement Field Work

SFDPH conducts navigation services to support linkage and re-engagement through LINCS, currently staffed with 1.5 FTE Navigators who work to re-link people to HIV care within 90 days. When they receive information from a medical provider about an HIV-positive patient who appears to have fallen out of care, the Navigators use a variety of different data sources to try to track down the patient. They then reach out with a combination of phone calls, texts, emails, letters, and in-person visits, in accordance with the well-established tenets of contact tracing used by DIS to contact someone for partner notification services following an HIV or syphilis exposure. Once our LINCS Navigators find a person and confirm they have indeed fallen out of care, they work with that person to assess barriers to care and help them be connected to a medical home – this has the added benefit of facilitating greater primary health care access for individuals who may otherwise still be uninsured and without regular medical care. Once an appointment for HIV care has been made, the Navigators facilitate them keeping the appointment, through reminders, provision of medical transportation, etc. as needed.

Currently, the LINCS program has the capacity to serve 200-300 clients per year. However, an analysis of HIV surveillance data leads us to believe that there are approximately an extra 4,000 people who are living with HIV in SF and not engaged in care. As discussed earlier, our data also show that we have significant disparities in HIV care and viral suppression, and those exist in MSM and TF,[24] which is why we are focusing on those groups. With this grant we will be able to changes to the LINCS program to greatly enhance our capacity and effectiveness, including:

1) <u>Expanding capacity of the LINCS outreach team</u>: Through this proposal we will be able to hire three additional Navigators, and this additional staffing will help ensure that we can do timely follow up for individuals who appear on the NIC list, especially those who are prioritized per decisions made as part of Activity 2. This will include the ability to do rapid follow-up for individuals named in a Partner Services interview (as HIV or syphilis contacts) – if they are determined by examination of HIV surveillance data to be known HIV-positive and NIC, they will be urgently contacted by the LINCS team. Similarly, our Navigators will be able to prioritize outreach to individuals who are HIV-positive, newly diagnosed with an STD, and appear on the NIC list. These changes should significantly increase the numbers of high-risk individuals reached by LINCS, and greatly improve the outcomes achieved by the program. **It will also allow us to strengthen the system for feeding updated data from field staff back to HIV surveillance through the PHNIX system,** as increased LINCS staff will support reporting of data back to HIV surveillance, better ensuring high quality program and surveillance data.

2) <u>Offering contingency management for those at highest risk</u>: Contingency management is a strategy based on the idea that a person will change behaviors voluntarily when they receive positive incentives (often financial) to support that change. Contingency management has been successfully used to facilitate the use of post-exposure prophylaxis (PEP) among MSM who use stimulants,[25] and also by the Positive Reinforcement Opportunity Project (PROP) in SF, which began as a pilot program of the SFDPH in 2003 to reduce methamphetamine use among MSM and was so successful[26] that it is currently still ongoing as a program of the SF AIDS Foundation. Though HPTN 065 (TLC-Plus) did not show a significant impact of financial incentives on viral suppression during their 3-year HIV research study, it ***<u>did</u>*** find that financial incentives increased the proportion of patients with an undetectable viral load in clinics where fewer than 65% of patients were undetectable at study start.[27] Given this, we are encouraged that we will see

positive effects of contingency management designed to improve HIV care retention for those members of the target population having significant difficulty remaining in HIV care.

We will offer contingency management to 300 individuals with pre-specified criteria associated with low likelihood of re-engaging in care. We will spend the first six months of the grant identifying those criteria through evaluation of the LINCS experience to date. Individuals in the contingency management program will be offered gift cards valued at $20 if they complete an initial primary care visit, $20 if they have recommended routine labs drawn, and a bonus of $60 (total $100) if they achieve virologic suppression within 90 days of re-linking to care. When a LINCS client meets the pre-specified criteria, the LINCS Navigator will provide the patient with information about:

- The number of cards available (3) during the 90 day enrollment period
- When the cards will be provided (right after the completion of the PCP visit)
- That cards will not be replaced if lost/stolen, and are the responsibility of the patient

The Navigator will track the provision of all gift cards, and if s/he does not escort the patient to the appointment, s/he will verify the patient's attendance via the EMR or by calling the clinic.

3) Using the Combination Health Department/Healthcare Provider Model: In 2014, 19 (58%) of 33 HIV-positive clients referred to LINCS by their primary care provider for assistance with re-linkage and engagement were identified by surveillance as having relocated or being in care elsewhere. After matching 118 referred patients from a SFDPH clinic to eHARS, 73 **(62%) were identified as having relocated or engaged in care elsewhere.**[28] This figure is especially relevant because a large portion of LINCS resources – in addition to resources of the provider – were spent following up on cases where people had simply chosen to see another provider for their HIV care, and not informed the original provider of that decision. Through this proposal, we plan to proactively offer this combination model of Data to Care as a service for providers in SF. This will have a number of benefits. First, it will allow medical providers and LINCS staff to spend more of their resources on those who are legitimately NIC. Second, it will lead to dataset improvements to be used for the Data to Care intervention overall, by proactively integrating provider data and allowing for triangulation using multiple data points. Finally, it will improve relationships between the SFDPH and private HIV care providers, helping to strengthen the effectiveness of the LINCS program overall for all people living with HIV in SF.

4) Building capacity for front-line HIV workers in HIV care clinics: Too often, the burden to improve retention in HIV care focuses on people living with HIV, with little attention given to the systemic obstacles faced by HIV-positive people and their providers alike. Structural barriers (e.g. hours of operation, appointment scheduling logistics, substance use and/or tardiness policies), rapidly changing systems of care, and a lag in technological advancements can all negatively affect retention rates. Additionally, cuts in administrative and training support provided to HIV frontline workers (non-clinicians and non-administrative staff) has made it especially challenging to ensure workers have a robust understanding of public benefits in an Affordable Care Act (ACA) environment, as well as knowledge of client retention best practices. For this reason, we have budgeted funding to hire skilled consultant(s) as Subject Matter Experts to work with frontline staff in clinics and community partner agencies that provide HIV care and wrap-around services to HIV-positive patients. This position will collaborate with

frontline staff to identify and mitigate factors that inhibit patient retention, increase cross-agency collaboration, and develop knowledge of PrEP and PEP. Additionally, they will provide technical support to reduce barriers and improve retention overall, thereby reducing the need for re-engagement in the first place.

Activity 3: Connecting PHNIX to External Clinical Data Systems

As was described earlier, PHNIX is scheduled to launch in the first year of this grant; however, functionality does not yet include integration of data from various clinical systems, such as the AIDS Regional Information and Evaluation System (ARIES), a centralized HIV/AIDS client management system that allows for coordination of client services among medical care, treatment and support providers, and provides comprehensive data for program reporting and monitoring. Based on the national CareWare system, ARIES is used by Ryan White-funded service providers in California. Through this proposal, we have planned for 300 hours of system developer time to explore feasible options and map at least one major care system, building functionality into PHNIX to integrate the information for use in Data to Care activities. This will be strong enhancement to our current system, and will allow for far more accurate information to be used in Data to Care than with use of eHARS and STD surveillance data alone.

C. APPLICATION EVALUATION AND PERFORMANCE MEASUREMENT PLAN

Routine monitoring, evaluation, and quality improvement of public health activities is essential to ensuring services are delivered in a timely and efficient manner and that data are used effectively. Therefore, throughout this project we will:

- Evaluate our current business processes, data collection practices, and data systems for identifying high-risk clients for PrEP as well as clients NIC or with unsuppressed viral loads
- Enhance our current data collection and data uses to monitor PrEP activities
- Maximize and integrate secondary data sources to enhance PrEP and Data to Care activities
- Develop quality assessment tools to ensure high quality PrEP data and HIV surveillance data
- Develop predictive analytics, real-time reporting tools, and dashboards to monitor performance on key project indicators

The details of our demonstration project activities, including program monitoring and evaluation, and quality assurance activities, are available in our **Work Plan** included with this application. That Work Plan demonstrates that we will immediately start many program activities at funding start; those that require planning and start-up will be ready for launch within 6 months of the start date. **Table 3 on the following page identifies our project goals and objectives, evaluation questions, data collection strategies, and utilization of results.**

Table 3. Performance and Evaluation Plan Matrix

CATEGORY 1: PrEP						
Goal	**Objective**	**Page Ref**	**Evaluation Question(s)**	**Data Collection/ Analysis Activities**	**Who responsible?**	**Results will be...**
Increase the number of PrEP prescriptions for people at substantial risk of HIV in San Francisco, especially MSM and transgender persons, particularly persons of color	By 6 months into the project period, complete analysis of existing data and additional needs assessment for the target population and providers, identifying barriers to PrEP use and recommended strategies to improve PrEP uptake and adherence	5	-What are the barriers to PrEP for the target population? -Where are the target populations seeking care? -What are the barriers to providing PrEP to the target population seeking care?	-Analysis of routinely collected surveillance data -Targeted questionnaires -Focus groups	Senior Epi, Health Educator	Refined strategies to increase PrEP knowledge, uptake and adherence, and guide provider training
	By the end of year 1, we will have final plans, policies, procedures and protocols to implement PrEP activities for the target population	5	-Have the final plans, policies, procedures and protocols been developed for each setting identified?	-Documented plans, policies, procedures and protocols	Epi PrEP Specialist, Epi Informat/SD	Final plans, policies, procedures and protocols M&E Plan
	By the end of year 1, we will have launched a citywide social marketing campaign to encourage PrEP use among our target population	5	-What information and messaging do members of our target population need to increase interest in, uptake, and adherence to PrEP?	-Counts of media events, website hits, and similar metrics	Health Educator	Increased number of persons self-referring for PrEP to clinics/providers
	By the end of year 1, the SFDPH will have established policies, procedures and protocols to enhance current data systems to integrate services and share data across applicable sites.	6,7	-What enhancements to PHNIX will facilitate integration of PrEP services, monitoring, and evaluation into current SFDPH program activities?	-Information system development requirements	Epi PrEP Specialist, Epi Informat/SD	New business rules that facilitate integration of PrEP services, M&E of program activities
	By the end of year 1, we will have created and disseminated at least 3 new provider educational materials/tools, reaching ≥1000 target pop members	7,8	-What information, training and practice support does provider need to increase or improve PrEP delivery?	-Counts of materials and tools finalized	Health Program Coord.,NP, Health Educ.	Final materials and tools to support providers in prescribing PrEP
Reduce the number of new HIV infections among MSM and transgender persons in San Francisco	By the end of year 3, at least 75% of ≥200 providers reached through academic detailing will be actively prescribing PrEP to their patients.	8	-What strategies appear to have the greatest impact on provider interest in training to provide PrEP to the target population?	-# of providers trained, attendance logs -PrEP prescriptions	PrEP Coordinator, Senior Epi	Improved rates of PrEP prescriptions for target pop. by trained providers
	By the end of years 2 and 3, we will have conducted at least 6 videoconference consultations for PrEP each year in one or more of our new "Communities of Practice"	9	-Does the videoconference format work sufficiently to support providers engaging in the communities of practice for PrEP?	-Counts of videoconferences –Summaries of participant evaluation forms	Health Program Coordinator	Increased comfort with prescribing and managing PrEP among providers in COPs
	By the end of each project year, SFDPH will complete four Continuous Quality Improvement cycles, to officially document lessons learned from that year and accordingly, plan adjustment to project protocols for the future	19	-What were the major challenges we faced this year? -What changes to our project protocols are likely to lead to increased prescription of PrEP among SF providers?	-Staff meeting notes -Corrective action reports -Quarterly and annual reports	PI, Project Director, PrEP Coordinator Leadership Team	Improved PrEP activities in future years, to better serve our target population and providers

CATEGORY 2: Data to Care						
Goal	**Objective**	**Page Ref**	**Evaluation Question(s)**	**Data Collection/ Analysis Activities**	**Who responsible?**	**Results will be...**
Increase the percentage of MSM and TF diagnosed with HIV who are engaged in HIV care	Within the first 6 months of year 1, SFDPH will generate a prioritized list of the target population not in HIV medical care (the "NIC list") from eHARS.	13	-What adjustments are needed to the SAS code in eHARS in order to generate an optimal NIC list from existing data?	-Number of generated NIC lists - Log of NIC list code adjustments	Senior Epi, Epi/Data to Care (DTC) Specialist	Improved identification of target pop NIC
	Within the first 6 months of year 1, at least 3 new staff members will have been hired and trained to conduct outreach to our target population	14	-Have staff received all the appropriate training and orientation needed to well-versed in Data to Care strategies for this target pop?	-Documentation of hiring -Documentation of training	Medical Director City Clinic, DIS	Improved capacity of SFDPH to support retention for the target pop
	By the end of year 1, we will have protocols and standard operating procedures for Data to Care, including agreements for data sharing between health departments and health care providers when necessary	13,22	-What details must be documented to create completed procedures for generation of a NIC list via PHNIX? -Have the final plans, policies, procedures and protocols been developed for Data to Care?	-Documented plans, policies, procedures and protocols -Signed data sharing agreements	Epi Informatician /SD, System Developers	Improved capacity of SFDPH to support retention for the target pop through use of integrated data
Increase the percentage of MSM and TF diagnosed with HIV who have a suppressed viral load	By the end of year 1, we will have processes for integrating existing STD, Hepatitis and other surveillance data with lab reporting within PHNIX	13	-What datasets are available that would support Data to Care? -What processes are needed to complete dataset integration?	-System documentation and integration mapping	Epi Informatician /SD, System Developers	Improved capacity to support care retention through integrated data
	By the end of year 1, SFDPH will be able to generate a fine-tuned, prioritized NIC list of the target population from PHNIX	13	-What delivery format is most useful for LINCS staff to facilitate rapid action on the NIC list?	-Number of times NIC list generated from PHNIX	Epi Informatician /SD	Improved, useful identification of target pop NIC
	By the end of years 2 and 3, LINCS staff will have successfully contacted at least 500 additional people per year from our target population	14	-What are the barriers still experienced by LINCS staff preventing successful contact of people on the NIC list?	-Number of successful contacts from LINCS Navigators	DTC Navigators	Reduction in NIC rates for the target pop overall due to LINCS intervention
	By the end of year 3, the proportion of people in our target population who are not in care will have decreased to ≤15%.	14,15	-What are barriers to retention for people who remain on the NIC for at least 6 months after LINCS contact?	-Proportion of living HIV cases with a CD4/VL lab	Epi DTC Specialist, DTC Navig.	Reduction in NIC rates for the target pop overall
	By the end of year 3, the proportion of people in our target pop who are virally suppressed will have increased to 85%.	14,15	-What are the barriers to viral suppression for MSM and TF successfully contacted by LINCS?	-Proportion of living HIV cases with undetectable VL	Epi DTC Specialist, DTC Navigators	Increased viral suppression rates for our target pop
Increase survival of MSM and TF diagnosed with HIV	By the end of year 3, the proportion of our target population successfully engaged or re-engaged in HIV medical care within 90 days of being identified as NIC will have increased by ≥25%.	14,15	-What are the barriers to engagement and retention in HIV care for people who remain on the NIC for at least 90 days after successful contact by LINCS staff?	-Number of days that each person on the NIC list remained before care linkage	Epi Informatician /SD, DTC Navigators	Faster linkage to care after identification for f/u; Increased viral suppression
	By the end of year 3, the average number of days between identification of a person not in care and their successful engagement or re-engagement in HIV medical care will have decreased to 21	**14,15**	**-What are the factors that prevent rapid (<14 days) re-engagement in HIV care for people who are successfully contacted by LINCS** staff?	**-Average number of days that each person who appeared on the** NIC list remained	**Epi Informatician /SD, DTC** Navigators	**Faster linkage to care after identification for f/u; Increased viral** suppression in the

	days.			before care linkage		target pop
	By the end of year 1, we will have developed at least 3 monitoring reports within PHNIX that help us evaluate system function for Data to Care.	19	-What information should be routinely monitored? -How frequently should progress be monitored?	-Count of finalized monitoring reports	Epi Informatician /SD	Specific action plan for improvement of PHNIX for Data to Care intervention
	By the end of each project year, SFDPH will complete four Continuous Quality Improvement cycles, to officially document lessons learned from that year and accordingly, plan adjustment to project protocols for the future	19	-What were the major challenges we faced this year? -What changes to our project protocols are likely to lead to increased linkage and retention in care for our target population?	-Staff meeting notes -Corrective action reports -Quarterly and annual reports	PI, Project Director, Senior Epi	Improved Data to Care activities in future years, to better serve our target population and providers

SFDPH has a steadfast commitment to Continuous Quality Improvement (CQI) for all of our projects. This is especially true for Data to Care, since evaluation of this intervention is key to our continued use and improvement of the new PHNIX system. To this end, we have developed a detailed Data to Care evaluation model for PHNIX (available upon request) that includes activities, evaluation questions, enhancements to current data collection, and PHNIX development needs. Enhancements to this PHNIX system that will be developed and evaluated through this project will include matches to external databases not already included in the planned project roll-out, and expansion of navigation questionnaires to collect psycho-social factors and referrals to clinical/social services.

One of the key ways we will ensure CQI throughout this project will be quarterly CQI meetings with key project staff to review progress and document lessons learned, culminating each year in an official CQI review to revise the project protocols, logic model, detailed work plan, monitoring and evaluation strategies, and/or quality assurance activities as needed. This review will be conducted by the Project Director, in coordination with the Lead PrEP Coordinator, the LINCS team, the Director of the SFDPH Office of Equity & Quality Improvement, the Informatics Officer, and the PI. It will involve a series of in-person meetings with project staff, interviews with at least 5 medical clinicians who prescribe PrEP, and satisfaction surveys with members of the target population. Data gathered through these strategies will then be synthesized and analyzed by the Project Director or her delegate, discussed with other project staff as needed to gain context and deeper understanding, and written into a formal CQI report which will be distributed to all key staff and stakeholders involved in the project. The formal report will include an action plan, with specific recommendations and deadlines for changes to project plans, documents, and materials to improve quality of the project in the next year. In addition to dissemination of the CQI plan to project staff and key stakeholders, we are committed to disseminating project findings and lessons learned to policymakers, medical providers, and members of the target population. As we do with so many other initiatives, we will make presentations at community planning and SF Health Commission meetings; we will hold town hall meetings and community forums, and we will make data and summary findings available on our public website. Further, we look forward to contributing to dissemination efforts at the regional and national level, participating in meetings and conferences as well as submitting articles to peer-reviewed journals in order to advance the science of PrEP implementation and Data to Care worldwide.

D. ORGANIZATIONAL CAPACITY OF APPLICANTS TO IMPLEMENT THE APPROACH

The applicant and lead agency for the project is the SF Department of Public Health, an integrated health department with two major Divisions (see the attached *Organizational Chart*): the SF Health Network and the Population Health Division. Our mission is to protect and promote the health of all San Franciscans, and we are recognized as a public health leader, working closely with community organizations to implement innovative, effective, evidence-based strategies and enacting policies to build healthy, safe and equitable communities. We have an extensive track record of developing and implementing initiatives to promote sexual health and prevent the spread of HIV and other STIs in our city, especially for LGBT individuals. Unlike other public or private systems, the **SF Health Network** contains the crucial components needed to build a seamless continuum of care: patient- centered medical homes provided by primary care clinics located throughout the community; comprehensive behavioral health services including mental health and substance abuse; acute care and specialty hospital services; and other home- and community-based services. Through **PHD**, we assess and monitor the health status of San Franciscans and implement public health interventions.

Staffing Expertise and Experience

Both the Category 1 and Category 2 projects will be led by **Tomás Aragón, MD, DrPH.** Dr Aragón is the Health Officer of the City and County of San Francisco, and the Director of PHD. He will provide 0.1 FTE for this grant, and will be responsible for overall planning, implementation, monitoring, and reporting of the program. Dr. Aragon is trained in internal medicine (MD) and epidemiology (DrPH). He is co-PI of SF's Community Transformation Grant, and has extensive experience leading CDC program and research grants.

Dr. Aragón will be supported by **Susan Philip, MD, MPH**, who will serve as the Project Director at 0.2 FTE. Dr. Philip is the Director for Disease Prevention and Control for PHD. She will supervise and train the Lead PrEP Coordinator, and will work closely with other project leads to monitor short-term outcomes and maintain smooth implementation of all project strategies. She will also be responsible for tracking and annual reporting all activities to CDC.

Both Dr. Aragón and Dr. Philip will be supported by our stellar leadership team:

- **Dr. Susan Scheer, PhD, MPH,** the Director of the ARCHES Branch of PHD (HIV surveillance)
- **Dr. Stephanie Cohen, MD, MPH,** the Medical Director of SFCC and Co-Principal Investigator of the NIAID-funded US PrEP Demonstration Project
- **Ms. Tracey Packer**, the Director of Community Health Equity & Promotion for PHD
- **Mr. Israel Nieves-Rivera**, the Director of Equity and Quality Improvement for PHD
- **Ms. Jennifer Grinsdale, MPH,** the Public Health Informatics Officer and lead on PHNIX
- **Dr. Jonathan Fuchs, MD, MPH,** Director of the PHD Center for Learning and Innovation
- **Dr. Susan Buchbinder, MD**, Director of Bridge HIV (formerly SFDPH HIV Research Section) and head of the Steering Committee for the Getting to Zero Consortium
- **Dr. Albert Liu, MD, MPH,** Clinical Research Director of Bridge HIV; PrEP research specialist

All other details of the comprehensive staffing for this proposal, including further details of our staff experience, expertise, and contributions to this project, are available in the *Staffing Plan.*

Workforce Capacity and Competence

As with all our work, our effectiveness depends on the skills and expertise of our project team to deliver technically sound, culturally competent guidance. All staff must complete required online trainings each year, including privacy, data security, and documentation standards. The SFDPH is strongly committed to professional development, and our commitment to continue training along with our reputation as a cutting-edge, evidence-based health department has helped us to attract some of the best professionals in our field. As such, our project staff have exceptional skill and experience coordinating and facilitating development of trainings, policies, and educational materials. However, as described in Sections B1 and B2 (Approach) we have made specific plans to ensure that current and new staff members have adequate training to implement all demonstration project activities. Through CDC's Program Collaboration and Services Integration (PCSI) initiative beginning in 2010, we have made impressive strides toward implementation of a syndemic approach to the prevention of HIV/AIDS, viral hepatitis, STDs, and TB. We are already a model for integration of HIV testing and PrEP with other screening services, and this will only improve with the launch of PHNIX to allow for fully integrated data systems. Finally, as a result of the U.S. PrEP Demonstration Project we have already developed a robust model for referral of eligible clients to PrEP providers, which will be expanded through this grant.

Fiscal Management

The SFDPH manages a $14 million portfolio of CDC-funded HIV prevention, policy, surveillance, and research activities which will directly inform our work on this project. Responsibility for fiscal monitoring and oversight of government grants lies with a six member team based in the SFDPH Grants Unit and led by the Accounting Manager. The Accounting Manager establishes, evaluates and reviews fiscal procedures to ensure internal control and compliance and oversees and manages fiscal audits of Federal, State and private grants.

In order to hire new staff rapidly, we have started the process of requesting all new positions listed in this application through Human Resources and the Controllers Office. Upon the announcement of funding, we will be able to post the positions and begin the hiring process immediately. Additionally, we have a longstanding relationship with Public Health Foundation Enterprises (PHFE), a licensed CA non-profit that has served non-profit and research entities for over 39 years with fiscal, human resource, and contract administration services. Through PHFE, we can rapidly establish contracts with vendors and consultants to support project activities and manage all travel requirements, including staff attendance at all CDC grantee meetings.

Organizational Infrastructure

SFDPH employs more than 12,000 employees in two major hospitals, 21 primary care clinics, 28 behavioral health sites, and more than 30 branches and sections. We have offices and services locations in every neighborhood in the City, and run a state-of-the-art trauma center and inpatient hospital (SF General Hospital). We have or can access any and all types of equipment required for the completion of all project deliverables for any one of our dozens of research and program grants.

Information and Data Systems

SFDPH is served by a large Information Technology (IT) Division, which collaborates extensively with the Department of Technology and Information Systems (DTIS) for the City and County of SF. Together, these entities are able to internally host both Avatar, the electronic health record

system that supports Behavioral Health Services and serves 25,000 clients across SF, and PHNIX, PHD's new integrated IT platform for surveillance, public health action, and preventative services. Thanks to PHNIX, by the end of 2015, HIV data will be fully integrated into a single, web-based, client-centered information system. By the end of 2016, we expect full integration of HIV data with STD and hepatitis C program and surveillance data. Specifically, the first release of PHNIX will include written agreements for data sharing across programs for the purposes of Data to Care, and planned future releases (in years 1 and 2) will enhance Data to Care activities through integration with STD and Hepatitis surveillance data and referrals via existing programs to help identify members of our target population who are not in care.

Compliance with HIV Laboratory Reporting and Data Security Requirements

CA laws require all HIV-related laboratory test results, including CD4 and viral load test results, be reported to the local health department. We have identified all laboratories that perform HIV-related testing in SF and have established mechanisms to receive these test results on a regular basis. Additional laboratory reports are also obtained from medical record reviews or from other health departments for SF cases receiving care outside of SF. The reporting of CD4 and viral load tests is complete for cases receiving care in SF. The HIV-related test results are processed and updated in the case registry at least monthly. All CD4 (<200 and >=200) and viral load (detectable and undetectable) test results that matched to reported cases are maintained in eHARS and reported to CDC. Our HIV surveillance program meets the CDC requirements for laboratory reporting as of December 31, 2013 as outlined in the 2012 Monitoring Report. Each year, CDC benchmarks for completeness of laboratory reporting are met and exceeded.

In year 1 of the PCSI initiative, SFDPH developed an Integration Security and Confidentiality Guideline for the health jurisdiction, using CDC Data Security and Confidentiality Guidelines. All data collection, entry, management, submission, analysis, use, and dissemination procedures are consistent with these guidelines, and our data security and confidentiality policies conform with the NCHHSTP Data Security and Confidentiality Guidelines. We comply with all federal information systems and information processing security policies; our local procedures clearly describe required physical security attributes of all facilities; procedures for protecting, controlling, and handling data during performance of the project, including any development and testing activities; required limitations on employees with respect to the reproduction, transmission, or disclosure of data; physical storage procedures to protect data; procedures for the destruction of source documents and other contract-related waste material; and personnel security procedures. Procedures for electronic and physical data security and data sharing are reviewed and approved by the Overall Responsible Party (ORP) from HIV Surveillance.

All agency personnel having access to identifiable and confidential information receive appropriate annual training and sign confidentiality pledges; this is in concordance with our 'Rules of Behavior' for persons who have access to data systems through this project. We complete an annual review and validation for all system user accounts to ensure compliance and continued need for access. We will conduct a privacy impact assessment (PIA) on all information systems acquired, developed, or used in conjunction with data collected for this project, and work with CDC on an ongoing basis to review security controls and measures and ensure continued compliance with federal information security regulations.

Print Form

Introduction Form

By a Member of the Board of Supervisors or the Mayor

Time stamp
or meeting date

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

☒ 1. For reference to Committee. (An Ordinance, Resolution, Motion, or Charter Amendment)

☐ 2. Request for next printed agenda Without Reference to Committee.

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

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

☐ 5. City Attorney request.

☐ 6. Call File No. _____ from Committee.

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

☐ 8. Substitute Legislation File No. _____

☐ 9. Reactivate File No. _____

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

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

☐ Small Business Commission ☐ Youth Commission ☐ Ethics Commission

☐ Planning Commission ☐ Building Inspection Commission

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

Sponsor(s):

Supervisor Scott Wiener

Subject:

Accept And Expend Grant- San Francisco PrEP And Data To Care Demonstration Projects -$2,898,913

The text is listed below or attached:

Resolution authorizing the San Francisco Department of Public Health to retroactively accept and expend a grant in the amount of $2,898,913 from Centers for Disease Control and Prevention to participate in a program entitled San Francisco PrEP and Data to Care Demonstration Projects for the period of September 30, 2015, through September 29, 2016.

Signature of Sponsoring Supervisor: Scott Wiener

For Clerk's Use Only:

File No. 151194

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

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

Contractor Information *(Please print clearly.)*	
Name of contractor: Public Health Foundation Enterprises, Inc. (PHFE)	
Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. ***Use additional pages as necessary.*** *(1)* See attached Board of Directors 2015-16 list *(2) Blayne Cutler, Chief Executive Officer and Margarita R Buitrago, Chief Financial Officer* *(3) n/a* *(4) none* *(5) n/a*	
Contractor address: 12801 Crossroads Parkway South, Suite 200, City of Industry, CA 91746-3505	
Date that contract was approved:	Amount of contracts: $297,514
Describe the nature of the contract that was approved: PHFE will provide the staffing for data management and data dissemination; and field activities: including medical record abstraction and patient interview	
Comments: PHFE is a 501 (c) 3 Nonprofit with a Board of Directors	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form (Mayor, Edwin M. Lee)

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

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

_____
Print Name of Board

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

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

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

(Attachment)

Public Health Foundation Enterprise

PHFE Board of Directors 2015-16

Officers:	**Members:**
Erik D. Ramanathan, Chair	Teri A. Burley
Delvecchio Finley, Vice Chair	Amy Kircher
Tamara Joseph, Secretary	Edward Yip
Robert R. Jenks, Treasurer	Jean C. O'Connor
Blayne Cutler, Ph.D., M.D, CEO	Jeffrey Benson
	Santosh Vetticaden
	Scott Filer
	Susan De Santi
	Yolie Flores

File No. 151194

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

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

Contractor Information *(Please print clearly.)*	
Name of contractor: Consilience Software, A Xerox Company	
Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary. *Please list the names of* *(1) N/A* (2) *chief executive officer* - Joy Alamgir, *chief financial officer* - Kristen Krmpotich *and chief operating officer* - Mark Marostica (3) *none* (4) *none* (5) *none*	
Contractor address: 11305 Four Points Drive Bldg 1, Suite 150 Austin, TX 78726	
Date that contract was approved:	Amount of contract: $25,000
Describe the nature of the contract that was approved: Consilience Software will provide, as needed system development related to enhancements of the PHNIX system. These enhancements may include custom java coding, or specialized functionality that cannot be developed by SFDPH or other contractual staff.	
Comments:	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form (Mayor, Edwin M. Lee)

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

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

Print Name of Board

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

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

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

File No. 151194

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

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

Contractor Information *(Please print clearly.)*	
Name of contractor: Better World Advertising	
Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary. *(1) Les Pappas owner* *(2) the contractor's chief executive officer, chief financial officer and chief operating officer – Les Pappas holds all these positions* *(3) Les Pappas owns 100% of the corporation* *(4) none* *(5) none*	
Contractor address: 333 Kearny Street, Floor 7, San Francisco, CA 94108	
Date that contract was approved:	Amount of contract: $150,000
Describe the nature of the contract that was approved: To conduct a social marketing campaign to increase the uptake of Pre-Exposure Prophylaxis (PrEP) in the target population. Final scope of work will be developed based on the assessment conducted during the first six months of the project, and current formative evaluation funded through local funds, however we expect activities to include developing the social marketing strategy, implementing the campaign, producing materials and purchasing any necessary media space.	
Comments:	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form (Mayor, Edwin M. Lee)

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

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

Print Name of Board

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

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

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