San Francisco Department of Public Health
Center for Learning and Innovation, Population Health Division
Capacity Building Assistance for High-Impact HIV Prevention PS14-1403
Category A: Health Departments

A. Background

The HIV epidemic is at a critical juncture. Recent breakthroughs in HIV prevention and treatment have raised the possibility of a generation without AIDS. We know that once-daily pre-exposure prophylaxis (PrEP) is safe and effective and early treatment of HIV-infected persons can result in dramatic reductions in HIV transmission—findings that could alter the course of the US epidemic. Unfortunately, 50,000 new infections occur each year, with a concentrated epidemic among men who have sex with men (MSM), African American and Latino MSM, and African American women, particularly those from the South. Of those HIV-infected, one in five individuals is unaware of his/her HIV status, and less than a quarter are virally suppressed. In 2011, the **Centers for Disease Control and Prevention (CDC) refocused its programming and policy efforts to launch High-Impact Prevention (HIP)**. This translated into new funding priorities last year (CDC PS12-1201) for health departments to support *evidence-based*, *effective*, and *scalable* prevention interventions. CDC also redistributed resources to jurisdictions with the highest burden of HIV cases. This paradigm shift has coincided with unprecedented changes in the health care delivery system ushered in by the Affordable Care Act. Health departments that have been successful in navigating this evolving landscape have an important role to play in guiding community-level adoption of high-impact HIV prevention.

The San Francisco Department of Public Health (SFDPH) has long been a model for innovative, data-driven approaches to HIV prevention at the local level. Over the past several years, the SFDPH has partnered with local agencies, medical providers, and community groups to implement the National HIV/AIDS Strategy and address CDC's call for high-impact prevention. Through ongoing engagement, despite challenges along the way, San Francisco has been able to shift the emphasis from difficult-to-scale behavioral interventions to high-impact, bio-behavioral strategies. These include identifying HIV-infected individuals through expansion of testing in health care settings and targeted testing initiatives; intensifying efforts to link newly diagnosed and established HIV cases into care; and providing best-practice prevention strategies for HIV-negatives at increased risk for infection. The SFDPH was the first health department in the nation to implement a public policy of early initiation of antiretroviral therapy, among the first to implement pooled RNA testing of high-risk HIV-negatives to identify acutely infected individuals, and among the first to make post-exposure prophylaxis (PEP) widely available through the public health system. These and other steps have correlated with a **steady reduction in HIV incidence in San Francisco**.

Facilitating the sharing and uptake of best practices is a key function of any effective capacity building assistance (CBA) program. With significant changes underway in HIV prevention, we would expect that health departments would readily take advantage of CBA services; however, in 2012, only 17% of the 674 CBA requests filled for technical assistance (TA) or training were from health departments[1]. Through PS14-1403, the CDC has reconfigured its flagship CBA program to include health departments as possible CBA providers. The SFDPH has a twenty-year tradition of helping other health jurisdictions across the US and around the world

with HIV prevention work. As such, the SFDPH is well-positioned to become a national CBA provider. We **have several key strengths**: **broad expertise** in developing, evaluating, and implementing evidence-based, bio-behavioral HIV prevention; the necessary **organizational infrastructure** to commit to a large scale training and technical assistance effort; extensive **experience** working with local, tribal, state and territorial health departments; and a **collaborative approach** with partners that builds effective relationships and ensures local sustainability. Furthermore, we embrace the philosophy that CBA is most effective when offered by peers who understand the challenges of implementing high-impact prevention.

The SFDPH CBA Team will be led by Dr. Jonathan Fuchs, Director of the Center for Learning and Innovation (the Center), a branch of the newly integrated Population Health Division dedicated to the professional development and capacity building of the public health workforce. The SFDPH is a leader in **HIV Testing**, **Prevention with High-Risk HIV-Negative Persons**, and **Policy** and will offer **peer-to-peer** capacity building assistance to health departments across the country in these three high-impact prevention areas.

B. **Approach**

i. **Purpose**

The overarching goal of the CBA program is to strengthen the capacity of health departments to plan, implement, and sustain high-impact HIV prevention interventions. As a local health department with a long history of collaboration with CDC and significant experience in providing support to regional, national, and international health departments/ministries of health, we are prepared to implement and roll out a comprehensive range of sustainable CBA activities. We will disseminate useful state-of-the-art **information**, build skills through online and face-to-face **training**, and offer customized, culturally appropriate **technical assistance (TA)** to enhance the uptake and implementation of high-impact prevention and supporting activities in the areas of HIV Testing, Prevention with High-Risk HIV-Negative Persons, and Policy.

ii. **Outcomes**

The SFDPH will establish a national CBA program that offers high quality, culturally and linguistically appropriate state-of-the-science programs to support public health professionals in their efforts to implement high-impact HIV prevention. As a key component of our dissemination strategy, we will develop an **online CBA portal—**a specialized, secure website that will allow us to track how health department staff access the information, training, and TA we provide. This online CBA portal will complement the **CDC Capacity Building Request Information System (CRIS)** by enabling us to refine our list of engaged "customers", monitor uptake of our CBA services, and track our key program outcomes over time. The SFDPH aims to achieve the following outcomes **over the 5 year project period** in the areas of high-impact HIV Testing, Prevention for High-Risk Negative Persons, and Policy:

1) **Increased accessibility to and availability** of our CBA services as measured by at least one staff member from 90% of health departments registering for our online CBA portal and reporting knowledge about our services.
2) **Increased utilization** of the Center's CBA services as measured by at least 70% of online CBA portal users accessing our training and/or one-on-one technical assistance, and at least 80% of those who access these services reporting high levels of satisfaction.

3) **Increased knowledge, skills and/or self-efficacy** to implement high-impact HIV Testing, Prevention with High-Risk HIV-Negative Persons, and Policy compared to baseline, as reported by at least 90% of CBA recipients after receiving these services.
4) **Increased capacity to implement high-impact HIV prevention** with at least 80% of recipients reporting intent to use acquired knowledge and skills.

iii. **Program Strategy**

We will describe our Program Strategy by first discussing the **theoretical underpinnings** of our approach to CBA and how we **assessed priority CBA needs**. We then propose **specific activities** that will advance the three main forms of CBA: information dissemination, training, and technical assistance. Next, we will offer a plan to **market our CBA services** to encourage uptake, describe our **target population** (i.e., health departments and the communities they serve), outline our goals to be **inclusive**, ensuring health department staff can access CBA. Finally, we will describe our **collaborations with local and national partners** to implement our national CBA program.

Theoretical Framework and Assessment of Strengths and Needs: To accomplish the outcomes described above, the Center's CBA program will utilize several strategies that hinge on three key behavioral change, social and system theories.

Table 1: Theoretical Framework for CBA Delivery

Theoretical Underpinning	Description	Application to CBA Provision
Diffusion of Innovation[2]	Diffusion of Innovation theory posits that for an innovation to be accepted broadly, the advantage of integrating it into practice must be clear and compatible with the local context. Diffusion theory also predicts that early adopters and peer opinion leaders will be the most influential agents of change.	Information and training activities must provide a compelling and relevant rationale to encourage adoption of evidence-based practices. CBA providers must develop an understanding of health department stakeholders and their ability to influence and drive change.
Social Cognitive Theory[3]	According to social cognitive theory, a confident, well-prepared CBA provider, who has strong evidence supporting his/her recommendations will be most likely to succeed in supporting improved self-efficacy of other staff. This theory also asserts that people learn from others who model "skilled" behavior.	The CBA program will bolster CBA provider preparedness by offering training and coaching on being an effective mentor and/or trainer to maximize TA effectiveness, and ultimately, increase uptake of recommendations.
Readiness to Change[4]	Comparable individuals, communities, and organizations can be at different stages of readiness to receive CBA. Assessing readiness to receive CBA and to integrate new knowledge or behavior into practice can help determine which organizations should have priority for receiving CBA. Applications of this theory can also identify the most effective CBA methods for a given context.	Health departments participate in face-to-face training and TA activities based on their receptiveness and readiness to adopt evidence-based prevention recommendations. Prioritizing specific health depts. for particular CBA activities will be done in close collaboration with CDC.

Given the CDC's decision to concentrate resources for high-impact prevention activities in jurisdictions with the greatest burden of HIV, we will focus our CBA activities in these jurisdictions. We refer to this approach as ***high-impact CBA***—evidence-based and tailored to the communities most heavily impacted by the epidemic and who have the most to gain from CBA.

In preparation for this application, we turned to several sources to learn about CBA needs of health departments. These sources included 1) key informant interviews we conducted with 10 health departments, several of which participate in the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS), 2) results from a recent National Alliance of State and Territorial AIDS Directors (NASTAD) survey of funded health departments, 3) summaries of CDC key informant interviews focused on CBA services, and 4) the CDC Capacity Building Branch's 2012 year in review report. Below we offer a partial inventory of needs that emerged from these sources and therefore informed our CBA programmatic strategies:

Content Areas

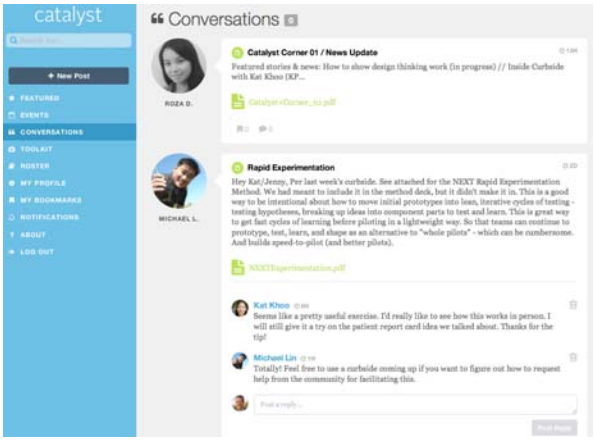
- **How to overcome *provider resistance* to implementing HIP and scaling back services for low prevalence populations**
- **How health departments should integrate *health care reform* and HIP efforts**
- **How to create *online tools* than can enhance HIP delivery**
- **How to use *surveillance data to plan* and target resources**
- **How to set up and maintain *partner services* relevant for high-risk populations (e.g., Black MSM)**
- **How to use *social media* effectively to engage hard-to-reach populations**
- **How to finance *PrEP and PEP***
- **How to integrate *new HIV testing technologies* (e.g., 4th generation antibody testing)**

Delivery Methods

- ***Low-cost, and flexible ways to access CBA* that will minimize travel**
- ***Templates* and tools that are easily adaptable; avoid "recreating the wheel"**
- **More *opportunities to share* experiences, best practices, challenges, and solutions**
- **Intensive, engaging, and practical *in-person workshops***
- ***Access to new online and mobile health (mHeatlh) technologies* that can support HIP for providers, patients and clients**

Program Strategies

The Center's CBA program will build on the success of SFDPH's capacity building efforts to offer innovative CBA solutions that are **evidence-based**, **responsive, tailored to the cultural and linguistic context, engaging, and flexible**. Unlike many CBA programs that rely on external consultants or hired trainers who may lack practical, day-to-day experience in planning, implementing and evaluating HIP activities, we will tap our experienced SFDPH team members to deliver CBA services. During the start-up phase as a CBA provider, we will conduct a **mixed methods assessment** of health departments' needs and strengths using a brief online survey and key informant interviews. We will work collaboratively with CDC and other CBA providers to further refine content foci and delivery strategies. Information from our needs assessment will also inform **how we adapt the user-friendly online portal** used by our Center's Innovation Hub ("Catalyst") to facilitate the exchange of ideas. **The online CBA portal** will be a key mechanism to enable information dissemination, training and technical assistance. Our CBA strategies are further described below.



Information Dissemination

This refers to the distribution and sharing of relevant and current high-impact HIV prevention information that will **undergo expert peer review.** Peer review will be performed by our **Executive Steering Committee** comprised of SFDPH Population Health Directors, many of whom are nationally recognized leaders in HIV prevention (see Letters of Support in Section 5). We will disseminate a carefully selected mix of website links, presentations, and tools through our online CBA portal. Each of the activities presented below are distinct, but complementary, to ensure public health professionals have the knowledge and tools they need to implement high-impact prevention. A summary of information dissemination activities for Year 1 is shown on page N-35.

***a. Disseminate "shovel ready" templates, protocols and fact-sheets*:** SFDPH has been a national leader in implementing high-impact HIV prevention strategies, and many health departments have requested local reports, protocols, and policy for adaptation (e.g., navigation and linkage to care), Request for Proposals (RFPs) for community agencies, and fact sheets. As discussed above, health department staff reported that having access to these templates would be enormously helpful given their limited time and resources. The SFDPH already maintains a catalogue of over 100 presentations, protocols, tools and templates that are "shovel ready" (i.e., ready to use and share) and we are prepared to disseminate the highest priority materials through our online CBA portal. We will review these materials with our Executive Steering Committee on a regular basis to ensure they are up-to-date and post new ones based on availability and value of these resources to our peers.

b. Develop user-friendly toolkits: During the program period, we will develop several toolkits that synthesize and package useful resources to support high-impact prevention implementation. For example, an important planning activity involves the interpretation of behavioral data in at-risk groups to drive HIV prevention programming. However, the complexity and sensitivity around assessing behaviors associated with HIV acquisition and transmission have resulted in a proliferation of questionnaires used by health departments and researchers. In addition, different tools and instruments are needed for different populations and contexts. In response, **our team at SFPDH and our colleagues at UCSF are in the process of archiving and standardizing behavioral risk assessment tools** from around the world to provide partners with consistent, validated, field tested, and documented questionnaires. We will package the instruments, all field-tested and tailored to be culturally and linguistically appropriate, along with template protocols for their application to populations at high-risk for HIV, as an online toolkit that is freely downloadable and editable. Additional toolkits that we may develop include PrEP/PEP implementation, organizing a partner service program, and using social media to reach at-risk groups.

c. Create PHIL (Public Health Innovation and Leadership) talks: Information, delivered in new and exciting ways, can spark innovative ideas. We will adapt the concept of the well-received TED talks that share "ideas worth spreading" (http://www.ted.com). We will produce short, 5-18 minute videos that feature compelling speakers and use straightforward, but powerful visuals and storytelling to inspire action. Effective PHIL talks will meet the **SCORE** criteria: **simple**, **clear**, **original**, **relevant**, and **entertaining**. We have identified several interesting and passionate speakers to offer these talks on cross-cutting topics such as "academic detailing" to influence health care providers to prescribe PrEP in high-risk HIV-negative persons and antiretrovirals in newly diagnosed individuals, and the power of storytelling to reduce HIV-associated stigma —an impediment to testing and engagement in care. Unlike webinars which are typically longer presentations that can be quite effective at delivering technical training at a distance, PHIL talks will be short, non-technical presentations that aim to inspire new ideas or thinking. These short videos will be disseminated through our online CBA portal.

d. Publish "State-of-the-Science" blog posts: HIV prevention science is a rapidly changing field. Research and implementation best practices are presented at a wide range of HIV and STD-focused conferences and technical workshops. Our key informants shared with us that it is not possible to attend every conference, and it is challenging to keep up with the rapid pace of

information disseminated from multiple channels. SFDPH faculty regularly develop "report-back" presentations for the health department and local CBO and provider audiences, as well as publish focused reviews of conference proceedings. For the past three years, Dr. Susan Buchbinder has published in Topics in Antiviral Medicine[5], a review of key HIV prevention-focused presentations at the Conference on Retroviruses and Opportunistic Infections (CROI), a leading HIV-focused scientific meeting. Our faculty will publish a monthly "State of the Science" blog to ensure scientific, programming and policy advances are communicated broadly for our health department audience. The online CBA portal will serve as an *e-café*, making it easy for health department staff to post their reactions and engage in discussion.

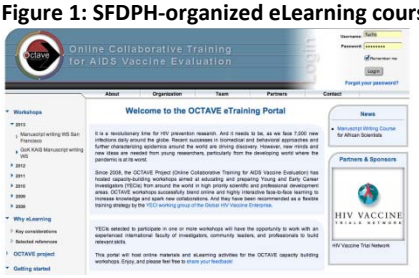
Training for skills development

Training refers to the development and delivery of curricula and coordination of activities to increase knowledge, skills, and abilities of health department staff responsible for implementing high-impact prevention. We will employ **adult learning principles**[6] that encourage **problem-based and collaborative approaches** rather than purely didactic ones. With health departments dispersed across the country, it would be logistically impractical and cost prohibitive to rely solely on face-to-face training. A recent meta-analysis published by the Department of Education[7] confirms the value of online training, delivered as self-directed learning modules or in a blended fashion combining online and face-to-face instruction. Our group is highly experienced in using web-based instruction in both of these formats [8,9]. The Center will leverage its robust **learning management system (LMS)** that supports self-directed and communal learning. **The LMS will be an integral part of the new online CBA portal**, requiring only **one username and password** to access eLearning and social networking features. A summary of training activities for Year 1 is shown on page N-35.

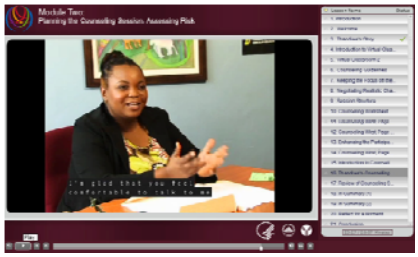
***a. Host monthly webinars*:** We will assemble subject matter experts to lead engaging 90 minute sessions that combine lectures and facilitated question and answer sessions that will be delivered over the Internet. Sessions will be recorded and available for streaming or downloading from our online CBA portal to be watched on a desktop computer or on a mobile device. Several topics will be prioritized including implementation of the Affordable Care Act and implications for HIV testing and care, and strategies to optimize testing and linkage to care in emergency room settings, among others (see page N-32 for a list of planned speakers and topics). We will work closely with other funded CBA providers to coordinate webinar subject emphasis and scheduling.

***b. Develop eLearning courses*:** CDC continues to make substantial investments in distance learning. According to the 2012 CBA year in review, CDC has worked with a number of partners to create several web-based courses and has others in development. As shown in Figure 1, we have extensive experience developing eLearning courses for a wide range of audiences. Our courses use varied interactive methods including virtual classrooms, videos of counseling sessions, online chats, animations, and user-friendly designs to easily navigate the courses.

Figure 1: SFDPH-organized eLearning courses



octave.bio-med.ch



hivcounselingtraining.org

gpptraining.bio-med.ch

In partnership with an NIH-sponsored international curriculum development team, the Center's staff created a 10 module e-Learning curriculum for clinical research teams conducting **individual and couples-focused risk reduction and adherence counseling** grounded in CDC-supported evidence-based practices[10,11] and was shown to improve knowledge and clinician/counselor skill[8]. Most recently, in close collaboration with our eLearning course development partner, *SweetRush*, we used **virtual whiteboard animations** to create a low-cost and engaging series of short modules that illustrate the UNAIDS Good Participatory Practice guidelines. Finally, the SFDPH leads dissemination of online training about the FC2 (female condom); click here to access this training. Additional trainings developed are described on page N-25. All eLearning modules will be accessible using both personal computers and mobile devices, such as tablets and smartphones. This provides tremendous flexibility and encourages users to access the training anywhere, anytime. Course topics may focus on areas such as detection of acute HIV, PrEP/PEP implementation, and use of social media to engage at-risk populations. Final topic selection and course development will rely on substantial input from CDC, health departments, and other CBA partners.

c. Host boot camps: We will host annual, intensive 2-day workshops that focus on local implementation of high-impact prevention interventions. PrEP serves as an excellent example of such an intervention that currently lacks sufficient uptake[12] despite strong evidence of safety and efficacy[13], interim CDC guidance for its use[14], and several modeling studies that show the cost-effectiveness of PrEP for MSM in the US, particularly when targeted at the highest risk subgroups[15-17]. While PrEP has been identified as a component of high-impact prevention, health departments have dedicated relatively few resources to promote it. Similarly, community awareness of non-occupational PEP is low in many communities[18]. The recent protests by PrEP and PEP advocates in New York City about the perceived lack of PrEP/PEP access highlight the need to focus on the role health departments can play in providing high quality information about PrEP and PEP to the public, providers, and at-risk groups. **SFDPH, along with partners from Miami and Washington D.C., is leading the first PrEP Demonstration Project in the US**—key lessons learned from this experience and implications for broader roll-out will be the focus of our first boot camp (see page N-32 for a sample agenda). Other high-impact prevention and professional development topics that are ideal for intensive boot camps include organizing partner services, running syringe exchange programs, establishing quality assurance programs in HIV testing, and manuscript writing.

***d. Organize short courses timed with HIV prevention meetings*:** Coordinating workshops or summits to co-occur with larger scale scientific meetings and other conferences is a cost effective and impactful way to reach our target audiences, and also provides an opportunity for collaboration across different CBA providers. For example, in collaboration with the Pacific AIDS Education Training Center (PAETC), we will host a one-day summit on eliminating perinatal HIV transmission, timed with the National HIV Prevention Conference or United States Conference on AIDS (see page N-33 for a sample agenda). Additional opportunities for CBA can be arranged to coincide with CROI or the National STD prevention conference. Faculty experts will engage conference attendees in person and through webcasts to give remote attendees a chance to participate.

Technical Assistance

Technical assistance (TA) is the provision of tailored guidance to meet an organization's specific needs through collaborative communication. Assistance takes into account institution-specific circumstances and culture. TA can be categorized as ***Push*** or ***Pull***. ***Push* TA** is generated by proactively integrating emergent knowledge, research findings and technology into program practice and is continuously revisited to ensure technical assistance is timely, relevant, and useful. ***Pull* TA** begins when the recipient health department requests TA that they believe they need. Pull TA requests will be generated formally through the CDC CRIS system. CBA faculty will evaluate needs and deliver brief and in-depth TA through conference calls, video-conference, and face-to-face visits. To ensure we are delivering high quality, client-centered TA, **all TA staff will receive comprehensive training** that will emphasize the goals of the program, cultural competence, and highlight best practices in coaching and mentoring. Ongoing monitoring and evaluation will support continuous quality improvement. A summary of TA activities for Year 1 is shown on page N-35 and N-36.

a. Deliver client-centered, one-to-one technical assistance: The cornerstone of effective TA involves one-to-one support of health department staff based on formal requests generated through the CRIS system. Brief TA will be delivered via email, teleconference, or video-conferencing (using SKYPE or formal videoconferencing if available at partnering health departments). More extensive TA needs can use a combination of modalities, including face-to-face visits.

b. Use the social networking features of the online CBA portal to support health department communication and sharing of problems, solutions, and best practices: The CRIS system provides a systematic approach to request, deliver, and monitor TA. However, key informant interviews with health departments reinforced the need for additional ways to connect to experts. Online social networks are increasingly popular among health professionals, and our online CBA portal will support easy-to-use discussion forums and individual messaging capabilities between users. In addition, **our subject matter experts will hold regular "office hours" that combine voice and online chat** to provide focused technical assistance to health department staff who call in or submit questions via online chat. A schedule of SFDPH experts and themes covered each month will be shared broadly. If interest is strong, we can increase the frequency of office hours. We anticipate this approach will foster greater access to our experts and generate new TA requests through the CRIS system.

***c. Facilitate peer-to-peer mentoring*:** Mentoring that happens within and between organizations has become increasingly common and can be an effective way to facilitate knowledge creation and adoption of evidence-based practices [19]. Based on the Center's extensive work in blended learning with young HIV prevention scientists (face-to-face workshops combined with online learning and collaboration), we will **convene regional kickoff meetings focused on a HIP topic area, followed by facilitated online discussion.** We will pilot and evaluate the approach in collaboration with the Alameda County Health Department, and the seven other Bay Area County departments. Lessons learned will be applied to future work with different regional groups. Given the intense epidemic in the southeast and our ongoing collaborations with the Houston Health Department and University of Miami in the areas of HIV testing and PrEP, respectively, we will organize a **regional meeting focused on novel HIV testing and linkage strategies with at-risk communities, including high-risk heterosexual women.** We anticipate that the strategy of using face-to-face kickoff workshops to cement strong working relationships followed by peer-to-peer mentoring through the CBA portal will spark new collaborations between departments and the piloting of novel high-impact prevention strategies.

***d.* Assistance with implementing online and mHealth tools:** Health departments are actively exploring new technology-based solutions to link clients, patients, and providers to HIV prevention tools and resources in the community. Many successful models already exist, yet few health departments have the funding or experience to contract with technology vendors to customize these tools. We propose to leverage our existing collaboration with **RDE Systems** to make their successful online and mobile health tools **freely available to CDC-funded health departments and their local collaborating CBOs and health care organizations**. RDE Systems is a HRSA-funded technology company nationally known for its HIV/AIDS health records management software. Their eCOMPAS online resource guide uses geospatial mapping and service filtering to connect clients to testing, care, and support services such as substance use and mental health providers, support groups, and housing assistance. This system has been designed to be highly scalable—health departments will receive a short tutorial, and with minimal administration time, enter local provider data in their jurisdictions. The system will send automated, annual email reminders to ensure provider information is up-to-date. The tool is already successfully used in several regions across the country such as New York, California, and North Carolina. In addition to eCOMPAS, **RDE has developed several tools**, including a **mobile application for community needs assessment** for use with low literacy populations. We anticipate that these and other tools will be highly valued as CBA products over the 5-year program period.

Marketing our CBA services: We recognize that our effectiveness as a CBA provider requires a strategic commitment to market our services. We can't rely on the notion that "we will build it, and they will come." As a new CBA provider, we will advertise our services via email blasts through CDC, NASTAD and other listserves. Our PHIL talks, blog posts, webinars, information and tools will solicit interest and drive traffic to our CBA portal and program. In addition, our portal will offer an opportunity to learn more about our CBA providers through their faculty profiles. All these activities will stimulate additional pull TA requests through CRIS. In addition, we will rely on channels used by CDC and the CBA Provider Network (CPN) to advertise offerings, post learning opportunities on the CDC Training Events Calendar (TEC), and participate actively in CDC Capacity

Building Branch CBA Provider Institutes. Finally, the Center for Learning and Innovation is a certified provider of continuing education credits for nurses, social workers, therapists, and health educators, and can confer credits for trainings completed online and/or face-to-face—an important incentive for public health professionals. See page N-35 for a summary of activities.

Target Populations: We are targeting state, tribal, local, and territorial health departments for CBA services funded by CDC for HIV prevention work. Nationally, we know that MSM account for the majority of new infections and are the only risk group in whom new infection rates continue to rise. According to CDC estimates, the number of new HIV diagnoses in MSM increased by 9% from 2008 to 2011, while decreasing 11%, 13%, and 28% in heterosexual men, women, and injection drug users (IDUs), respectively. The fastest rise is among MSM aged 13-24 (a 26% increase from 2008-11). African American youth are particularly affected, accounting for 58% of new diagnoses, an increase of 19% over that 4-year period. In addition, several social determinants of health fuel the epidemic in those hardest hit communities, including poverty; discrimination, stigma and homophobia; high undiagnosed/untreated STDs, higher incarceration rates among men, and language barriers and concerns about immigration status[18]. There is an urgent need for health departments to prioritize and target HIV prevention efforts in disproportionately affected communities and ensure that both individual and social determinants of risk are considered in the design and implementation of prevention efforts. These disparities and drivers will be an important focus of our CBA offerings.

Inclusion: The SFDPH CBA program will be inclusive to all health department staff and partnering CBO or health care organizations regardless of age, gender, race/ethnicity, sexual orientation, gender identity, disability, or socioeconomic status. This applies to all planning, implementation, and monitoring/evaluation activities. Given the concentration of the epidemic and new infections among MSM, African Americans, Latinos, IDUs, and transgender individuals, all CBA services will be designed to assist health departments so that they can ensure high-impact prevention activities are culturally and linguistically targeted to these populations to achieve the intended outcomes. While most of our materials will be provided to health departments in English, SFDPH and its partners are prepared to translate materials into Spanish or other languages, as needed. In addition, we plan to make our eLearning activities Section 508 compliant – a requirement of government and government contractors to make trainings accessible to those with disabilities. For example, we will ensure written transcripts of narrated eLearning content are accessible to hearing disabled staff.

Collaborations: The SFDPH will leverage several of its established partnerships and collaborations with CDC-funded entities, and those not funded by CDC, to support and promote the proposed CBA activities.

CDC-funded programs: SFDPH has participated in strategic planning activities with the 9 other *UCHAPS*-affiliated urban centers; together, these jurisdictions account for an estimated one-third of all new HIV infections nationally. Given the burden of disease in these epicenters, our CBA program will make a concerted effort to focus our needs assessment and CBA services with these and other heavily affected jurisdictions to maximize the impact of their HIV prevention activities. To implement our strategy of peer-to-peer mentoring, we will partner with the *Alameda County Dept of Health* (Moss and Francis) to host a Bay Area regional meeting and invite participation of regional health depts. We have partnered closely with the *Houston* and *Florida Health*

Departments to launch a southeast regional working group focused on novel engagement approaches to scale up HIV testing in at-risk groups, such as African American women. We have worked previously with Houston (McNeese and Wiley) on community-based approaches to scale up testing for African American youth. With *Kern County Health Dept.*, we are enlisting the expertise of Smith and colleagues to offer support to other jurisdictions in the area of third party billing for prevention services, for which they provided TA to other groups under a CDC-funded program. The SFDPH is strengthening our ongoing collaboration with the San Francisco-based *Asian & Pacific Islander Wellness Center*, a CDC-funded CBO and longstanding CBA provider to health departments and CBOs (Sheth and Mysoor). We will benefit from their expertise in developing an effective and efficient model to offer CBA, their innovative approaches to using social media, and the extensive work they have done in the area of cultural competency and assisting health departments from low and mid-range HIV prevalence jurisdictions. Through our HIV and STI prevention and control activities, we partner closely with the *California State Office of AIDS*. Finally, many of our SFDPH team members provide HIP expertise as invited faculty to the national network of *STD/HIV Prevention Training Centers* that will advertise our CBA activities.

Organizations external to CDC: We will partner with experts from two leading academic institutions—at *UCSF*, we will garner expertise in perinatal HIV transmission prevention and PrEP in women (Weber, Cohan, and Auerbach); testing and linkage to care from emergency room settings (Hare and Jones); and evaluation methods (Myers). Also with *UCSF*, we will co-organize with the Pacific AETC the proposed reproductive health and HIV prevention summit. In addition, we collaborate with the *University of Miami* as a site in the PrEP Demonstration Project and will work closely with our colleagues (Doblecki-Lewis and Kolber) to host the southeast regional peer-to-peer mentored workshop described above. Our partnerships with the *San Francisco AIDS Foundation*, a national leader in HIV prevention service delivery and policy organization, will focus on implementation of HIV prevention in the context of the Affordable Care Act (Mulern-Pearson) and the use of innovative social media approaches to engage at-risk groups (Canon). *Barnes and Conti, Inc.,* an organizational development group with whom we have done extensive work focused on change management, is prepared to offer TA to other health departments (Barnes). We also have ongoing collaborations with several technology, e-Learning, and media groups that will be tapped to implement our CBA strategies. Fuchs and Liu have an NIH RO1 grant looking at text messaging reminders to support PrEP adherence in collaboration with *RDE Systems*. For the CBA program, RDE will make their online and mobile health tools freely available to health depts. *Monarch Media* has created a customized learning management system for SFDPH which will be embedded in the proposed online CBA portal. *SweetRush* is an award winning e-Learning company that has produced modules with us focused on Good Participatory Practices in HIV prevention research; and *Alan Zucker Enterprises* is a highly regarded videographer who has produced videos for our eLearning projects. Finally, we've worked closely with *Conference Solutions* over the past 3 years to organize travel and plan US and international workshops. Please see Section 5: **Letters of Support**, and **Memoranda of Understanding** for additional information about our collaborations with CDC-funded and non-CDC funded partners.

iv. **Workplan**: *Please see the **detailed workplan** for year 1 and a high-level plan for the subsequent years on pages N-19 to N-42.*

C. Organizational Capacity to Execute the Approach

i. Organizational Capacity Statement

1.Organizational Mission, Activities, and Infrastructure

In 2013, under the leadership of Dr. Tomás Aragón, health officer of San Francisco, SFDPH reorganized its public health services into the new Population Health Division (PHD). Previously these services were provided by separate categorical sections, including HIV prevention. PHD is now community and client-centered with branches that specialize in health protection, health promotion, and disease prevention and control, and work together in multi-disciplinary teams to address complex community health problems such as HIV. These changes are closely aligned with the goals set forth by CDC's Program Collaboration and Service Integration (PCSI) plan. The Division has 520 staff, approximately 90 of whom are actively engaged in HIV prevention-related programs, surveillance, and research.

The changes within PHD have made clear the need for extensive training and capacity building internally to prepare staff to excel in their new roles. Dr. Aragón and Barbara Garcia, MPA, Director of Health, enthusiastically supported the launch of a centralized training and capacity building program within PHD (see letters of support and organizational commitment from Dr. Aragón and Director Garcia, respectively). Under the direction of Dr. Jonathan Fuchs, **the SFDPH Center for Learning and Innovation** was established, which will manage the proposed high-impact HIV prevention CBA program. The mission of the Center is to **foster a culture of learning and innovation** within SFDPH and to **share local expertise with regional and national partners**. The Center's activities fall within four key areas: leadership development training, internships, facilitation support for innovation projects, and capacity building. Since 2001, Dr. Fuchs has been an investigator with the HIV Vaccine Trials Network (HVTN) and has served as the co-Director for its training and capacity building program that supports 30 clinical sites in the US, Caribbean, South America, and Southern Africa as they conduct clinical trials of experimental preventive HIV vaccines (see Letter of Support from Dr. Larry Corey, HVTN Principal Investigator). To create a highly functioning and value-added CBA program for high-impact prevention, Dr. Fuchs will leverage his experience and lessons learned leading the HVTN training program that has successfully developed and implemented over **374 training activities in 4 languages for 11,490 trainees.** The Center also oversees other TA programs led by SFDPH experts including a California State-funded training program for HIV test counselors and a rapid Hepatitis C training program.

Our greatest strength as a national CBA provider to health departments is that we are a health department that employs a diverse and talented staff who will serve as mentors, trainers, technical assistance providers, evaluators, and content reviewers. Table 2 provides a partial inventory of SFDPH CBA faculty experts within the three component areas of HIV testing, Prevention for High-Risk HIV-Negative Persons and Policy, and lists relevant peer-reviewed manuscripts, abstracts and presentations that highlight their expertise in these areas. A full list of the CBA faculty members and expertise (along with the complete reference list) accompanies their biographies and CBA team CVs in Section 4.

Table 2. Selected expertise of SFDPH CBA Faculty members with direct relevance to a sample of CBA priority components

Domain	CBA Faculty Member	Areas of Expertise
Component 1: HIV testing		
HIV screening for at-risk populations in health care and non-health care settings, including routine screening for pregnant women	Philip, Fuqua, Knoble, Huriaux, Cohen, Bacon, Bernstein, Scott, Cohan, Weber, McCright, Wilson, Fann, Strona, Wolf, Kolber, Gilgenberg-Castillo, Doblecki-Lewis, Carraher, Pandori, Monico Klein, Hare	Non-healthcare setting testing for MSM, TFSM, IDU, and homeless women[20]; Integrating into primary[21,22] and emergency care[23-25]; Perinatal testing [26-29]; Mobile screening for high-risk populations; County jail based HIV rapid testing; Home-HIV testing/linkage programs for young MSM of color; Enhanced testing among African American MSM[30]; Screening for acute HIV infection [31-34].
Integration of new HIV testing into existing services; screening for other STDs, HBV, HCV and TB in conjunction with HIV testing, and referral and linkage to appropriate services.	Knoble, Huriaux, Coffin, Cohen, Bacon, Cohan, Weber, Bernstein, Pandori, McCright, Fann, Strona, Wolf, Kolber, Nguyen, Mysoor, Philip, Carraher, Monico-Klein	HIV testing among STD clinic attendees[35-37]; Integrating STD and HIV testing and linkage to care; Integrating HIV/HCV testing, including rapid technologies; Novel mobile-health strategies to improve linkage for people with HCV; Screening for STIs among newly HIV diagnosed [38,39]; Implementation of pooled RNA testing[40-42]; Integrating HIV testing into family planning sites; Integrated HIV/Hepatitis/STD testing model in county jails
Component 2: Prevention with High-Risk HIV-Negative Persons		
Behavioral Risk Screening for HIV	Knoble, Loughran, McFarland, Cohan, Weber, Wilson, Fann, Strona, Fuqua, Wolf, Nguyen, Mysoor, Macias, Scott, Buchbinder	Triaging clients for testing[43]; Linking low-risk clients to testing in healthcare settings; Working with HIV Prevention Planning Council (HPPC) to establish priority populations for testing based on epidemiological data; Using social marketing, media and the Internet to recruit high-risk negatives for HIV and STD screening[44]; Evaluating behavioral risk factors[45]; Outreach and testing for transgender individuals, including youth[46,47]; Identifying female partners of HIV-positive men and linking them to testing; Frequent HIV testing as a necessary component of MSM community-originated HIV seroadaptation strategies[48]; Behavioral screening for PrEP targeting[49]
Interventions for high-risk negative persons and negative partners in serodiscordant relationships, including pre- and post-exposure prophylaxis	Liu, Cohen, Bacon, Philip, Fuchs, Buchbinder, Knoble, Cohan, Weber, Fann, Strona, Wolf, Kolber, Bernstein, Doblecki-Lewis, Scheer, Thomas	PEP and PrEP implementation[50]; Implementation of PEP counseling, including in clinical settings; Conducting a PrEP Demonstration Project[51-53]; PrEP safety and efficacy[13,54]; Promoting adherence[51-53]; PEP/PrEP implementation for HIV-negative women with HIV-positive male partners[55]; Working with high positivity screening to expedite referral for PEP/PrEP; Personalized Cognitive Counseling[56]; Behavioral interventions for sexual risk related to substance use[10]; Community-based prevention strategies for Latino MSM[57]; Social marketing campaigns for MSM to reduce HIV risk [58-60]; Using novel technologies to increase access to sexual health information[51]
Component 3: Policy and Planning		
Strategies to better align prevention and care planning efforts, especially for underserved populations, including integration of HIV prevention and care planning bodies	Loughran, Cohan, Weber, McFarland, Schwarcz, Strona, Kolber, Mysoor, Packer, Fann, Jim	Prevention and planning councils integration efforts in San Francisco [61]; and sub-Saharan Africa (Botswana); Developing culturally competent and responsive planning and implementation for urban Native Americans, LGBTQ, African Americans, and homeless individuals, including plans for integrative care.
Analyzing epidemiological, behavioral, and other relevant data (HIV-related syndemics, and social determinants of health) to support HIV prevention program implementation	Raymond, McFarland, Wilson, Bernstein, Mysoor, Scott	Implementation and analysis of behavioral surveillance[47,62-65] Syndemics research[66]; Social determinants of health, Population size estimation[67]; Correlates of HIV risk[68,69]; Behavioral risk and use of prevention services by race/ethnicity[70]

SFDPH also possesses the **necessary infrastructure** to implement our national CBA program. Almost all of the HIV-associated training, programmatic and research groups are co-located under one roof at 25 Van Ness, a historic building in the heart of San Francisco's Civic Center, in close proximity to most of our consulting partners at the A&PI Wellness Center, San Francisco AIDS Foundation, and UCSF. This will promote excellent communication between the Center's core staff and the faculty to ensure responsiveness to CBA program requests. In addition, the SFDPH received a $9.6 million competitive grant from the NIH to renovate 17,000 square feet of research and training space. Completed in 2012, the Center has access to state-of-the-art conference rooms, enhanced information technology support, and videoconferencing equipment to support our national CBA program.

2. Experience and Management: The SFDPH manages a $14 million portfolio of CDC-funded HIV prevention, policy, surveillance, and research activities which will directly inform our CBA work. The Population Health Division has a **strong, centralized fiscal and grants management branch**, led by Christine Siador, MPH, who will ensure contracts are established in a timely manner. The Division has a longstanding relationship with Public Health Foundation Enterprises (PHFE), a licensed California non-profit that has served the non-profit, education, and research communities for over 39 years. As a fiscal intermediary, PHFE currently serves over 250 programs with combined budgets totaling more than $120 million dollars. PHFE provides fiscal, human resource, and contract administration services. Through PHFE, we can rapidly hire and onboard staff as well as establish contracts with vendors and consultants to support the proposed CBA activities. See Section 10 for letters of support from SFDPH and PHFE as well as a list of current CDC HIV grants.

3. Developing staff competencies: The effectiveness of the CBA program will depend on the skills and expertise of our CBA team to deliver culturally competent and technically sound guidance. All staff must complete required online training including privacy, data security, and documentation standards. Given that most of our trainers and TA providers hail from our institution or local partners (e.g., UCSF, API Wellness Center, San Francisco AIDS Foundation), we will offer an in-person **Orientation and Training workshop** that will focus on expectations of faculty, TA protocols and procedures, customer service, and cultural responsiveness. Faculty will be oriented to CRIS and our online portal. We'll also offer up-to-date information on HIV prevention science and review available resources on our website as well as the websites of the CDC, the CPN resource center, and other CBA providers so that our faculty can share these with other health departments during trainings/TA. We will **monitor individual TA provider performance data from TA recipient satisfaction surveys** so that we can provide individual level feedback to our CBA providers and offer assistance or additional training if improvement is needed. After the first 6 months of the program and then annually, we will review program evaluation data and convene the Executive Steering Committee and faculty to present data and solicit ideas on how the CBA program can be improved. We will pursue similar orientation and evaluation strategies with our off-site consultants, making use of distance learning and video-conferencing to ensure all providers across our program (including our colleagues from Kern County, Houston, and Florida) meet or exceed quality standards.

4. Training and Technical Assistance History: SFDPH team members have provided training and technical assistance **to local, regional, national, and international jurisdictions** in the areas of

HIV Testing, Prevention with High-Risk Negative Persons, and Policy. We have participated in several CDC organized working groups and task forces and hosted visiting officials from local and state health departments, community based organizations, and international delegations seeking to learn more about our advances in a number of areas, including HIV surveillance methods and their use in prevention program planning; scale-up of HIV testing and quality assurance activities, community engagement, PrEP implementation, data analysis, manuscript writing, and many others. Table 3 offers selected examples from the past three years of training and technical assistance provided to health departments and other organizations implementing high-impact prevention activities. Several letters highlighting training and TA strengths of our faculty can be found in Section 5.

Table 3. Examples of CBA provided by SFDPH team members in the past 3 years

Faculty Member	Recipient Health Department/Organization	Description of TA/training content and format, including demonstrable outcomes
Component 1: HIV testing		
Carraher	San Francisco DPH-run primary care clinics	Delivered clinician training and TA on implementing routine HIV screening in primary care settings. **Outcomes:** Increased HIV testing rates and improved use of aggregate testing data to monitor monthly improvement in clinic test rates.
Knoble	California State Office of AIDS; and Idaho Dept. of Health	Conducted face-to-face partner services implementation training and on-site TA for California jurisdictions. **Outcome**: Increased uptake of partner services in jurisdictions throughout California and Idaho.
Scott	Black AIDS Institute/UCLA African American HIV University, Los Angeles County DPH	Conducted didactic workshop on rationale and methods to support linkage to care and initiation of early antiretroviral therapy focused on African Americans. **Outcome:** Enhanced ability of attendees to institute best practices for linkage to care and initiation of antiretroviral therapy for African Americans.
Pandori	Missouri, Santa Clara, CA, and San Mateo, CA Health Departments; San Diego VA	Offered consultation on the advantages and disadvantages of currently available laboratory testing methodologies, and most appropriate options for sites. **Outcome:** Sites adopted 4th generation HIV antibody testing.
Component 2: Prevention with High-Risk HIV-Negative Persons		
Cohen	Pacific and Northwest Asilomar Faculty Development Conference Attendees	Co-facilitated intensive, hands-on train-the-trainer course in how to provide capacity building and education to potential PrEP implementers. **Outcome**: Increased self- efficacy of workshop participants to offer PrEP and teach others.
Strona	Atlanta, GA, Nashville, TN and Fort Lauderdale, FL Health Departments and funded CBOs	Offered on-site consultations to support the implementation of a contingency management intervention to reduce methamphetamine use linked with high-risk sexual behavior. **Outcome:** Sites implemented contingency management interventions with high-risk negative persons.
Strona	New York State; Boston, MA; State of OH; State of CA Health Departments	Conducted online training that presented methods to access web-based tools for partner services for HIV and STDs with high-risk MSM, including operational strategies to implement cultural competency both for staff and with community. **Outcome:** Review of current policy and standards, adaptation of current training methods for staff (train the trainer).
Component 3: Policy and Planning		
Huriaux	NASTAD, California State Office of AIDS	Offered consultation on Syringe Access & Disposal Best Practices. **Outcome**: Release of NASTAD Best Practices guidelines & State OA Best Practices guidelines.
Raymond	USAID/World Bank	Conducted didactic and hands on analysis workshop with ~22 city epidemiology teams to enhance their capability to analyze behavioral surveillance data. **Outcome:** Enhanced Philippines Dept. of Health capability in use of behavioral surveillance data.
Scheer and Pipkin	New York City Department of Health and Mental Hygiene	Technical assistance to enhance NYC HIV surveillance activities, laboratory reporting processes and medical chart abstraction activities. **Outcome:** Improved processes and workflow.

ii. Project Management and Staffing

A Core CBA team, based in the Center, will be responsible for implementing all programmatic activities, supported by **lead subject matter expert faculty** and Population Health Division Directors who will serve as the CBA **Executive Steering Committee**. Individual and organizational partners will provide additional expertise and service to implement the proposed strategies. Table 4 describes the staffing for the CBA program. We anticipate that many CBA programs will rely largely or exclusively on external consultants to deliver TA across the wide range of FOA-required components and competencies. Most of our **core CBA specialists and trainers are *in-***

house, allowing us to disseminate to health departments firsthand knowledge of on-the-ground HIV prevention work and planning. And to ensure our TA services are readily accessible and of high quality, our designated CBA specialists will work alongside our lead SFDPH faculty who will serve as mentors. CBA specialists will become highly proficient and increasingly offer TA independently. This model is **highly scalable** and will not detract from our ability to deliver on our core HIV prevention work in San Francisco. And as previously discussed, we possess **extensive capacity and availability of core SFDPH staff and consultants** with expertise and broad geographic reach to support our national CBA program. Additional details about staff expertise can be found in their submitted biographies and CVs in Section 4.

Table 4: Project Staff Roles, Responsibilities, and Qualifications

Name/Position	Roles and Responsibilities	Qualifications/Expertise
Jonathan Fuchs MD, MPH Director, Center for Learning & Innovation and CBA Program	Provides overall scientific, educational, and administrative leadership of project; liaises with the executive steering committee and RDE Systems to provide free, scalable online and mHealth tools for health departments; supervises the CBA Program Manager; provides fiscal oversight of subcontracts; serves as lead contact with CDC and attends all CDC-required meetings and trainings.	12 years experience leading an internationally recognized HIV vaccine training and TA program; conducts HIV prevention research in biomedical approaches as well as use of technologies for HIV prevention in HRNs. For 2 years, has directed the UCSF Center for AIDS Research mentoring program.
Oliver Bacon MD, MPH CBA Program Deputy Director and Lead Trainer	Delivers training and TA to health departments in the area of Prevention with High-Risk Negative Persons (HRNs) including biomedical prevention, STI testing, partner services and linkage to care; assists with program leadership and management; leads curriculum development, working with CBA specialists and Curriculum Development Specialist to create and deliver CBA.	For 5 years, co-directed the UCSF ASPIRE program which offered clinical training/TA to providers of HIV treatment and prevention services in 5 African countries; wrote and edited web content on HIV for 2 years at the UCSF Center for Health Information; serves as lead clinician for the PrEP Demonstration Project.
Jeannie Balido CBA Program Manager	Leads day-to-day operations of the program, including triage of CBA requests from CRIS and other channels as needed; coordinates personnel; manages reporting requirements to CDC and prepares required reports; supervises members of the core CBA team.	Has over 20 years experience in the areas of project management, conference/special events planning, social marketing and public relations. Former Program Manager for UC Berkeley Training Center; currently providing project management support for SFDPH.
TBD CBA Specialists (2)	Delivers training and TA to health departments in HIV Testing and Policy; CBA specialists will work in collaboration with internal/external faculty and complete all required documentation.	We will seek masters level educators with high-impact HIV prevention experience in the areas of HIV Testing and Policy.
TBD Curriculum Development Specialist	Develops, collects and organizes educational tools, talks, activities; creates courses; works with CBA specialists, internal and CDC subject matter and technical experts, and eLearning groups (SweetRush/Monarch Media) to develop and deploy eLearning courses.	We will seek a masters level educator with expertise in curriculum development, instructional design and eLearning.
Alecia Martin, MPH Senior Curriculum Advisor	Provides *in kind* mentorship to the Curriculum Development Specialist with a focus on interactive face-to-face training methods.	Has led the Health Education and Training Center for the Population Health Division since 2012. Designs and runs internal leadership, professional development, and change management training programs.
Ed Wolf Lead Trainer, Behavioral Interventions	Delivers training and TA in CDC-supported evidence-based behavioral interventions (e.g., Respect, Personal Cognitive Counseling, Adherence to PrEP and ART) will attend CDC-sponsored training of trainer skills-building workshops to enhance facilitation and training skills.	Has over 12 years of HIV testing counseling, supervision, and training. Expertise in behavioral interventions; 7 years of curriculum development expertise. Featured in award-winning AIDS Documentary, *We Were Here.*
TBD Communications Coordinator	Develops promotional materials; manages online presence (portal, website); moderates online discussion groups; organizes webinars; communicates with CPN resource center (in conjunction with project leadership and management), as well as other CBA providers to ensure coordinated delivery and marketing of CBA offerings; coordinates development of informational materials with CDC technical and SMEs.	We will seek an masters level communication specialist with extensive media relations and social marketing experience with a background in new media technologies and web content management
TBD Program Assistant	Schedules internal meetings, provides technical support to online CBA portal users and tracks CBA portal use; assists core team staff with CBA program activities.	We will seek an assistant with Bachelors degree-level education and/or commensurate experience.
Liz Kroboth Monitoring and Evaluation	Develops survey instruments; conducts key-informant interviews; works with project leadership to implement CQI activities; receives guidance/mentorship from senior M&E	6 years experience implementing and evaluating curricula, training, and mentored research experiences. Manages an NIH-funded program to encourage HIV

Specialist	specialist (Janet Myers, PhD at UCSF); coordinates M&E activities with CDC and other CBA providers.	undergraduates from underrepresented backgrounds to pursue HIV prevention careers; extensive eLearning expertise.
Lina Sheth, MPH CBA Implementation Specialist	Provides expert consultation on CBA protocols to project leadership and core implementation team; offers expertise in the areas of the interface between health departments and CBOs; offers special emphasis on collaboration with rural health jurisdictions and cultural competency.	Has over 19 years of HIV experience and executive level non-profit management experience; Skilled certified coach, facilitator and trainer with technical expertise providing CBA in organizational and leadership development.
Subject Matter Expert Faculty Leads	Provides senior technical knowledge and expertise to core team and project leadership in areas of HIV Testing, Prevention with HRNs, and Policy. Offers TA; mentors CBA specialists and assists with TA delivery and training (webinars, PHIL talks, etc).	Internal SFDPH subject matter experts with extensive experience and expertise. Please see the organizational chart and bios for further information.
Executive Steering Committee	Serves as a peer review body to the CBA program. Periodically reviews CBA materials and content for accuracy and value; reviews evaluation data and monitors project progress; makes recommendations for program development; advises Director.	Composed of nationally recognized leaders in HIV prevention programming, policy, and research. Please see the organizational chart and bios for further information.

To supplement internal expertise, the Center will maintain contractual arrangements with several organizations and their subject matter experts to expand the perspectives and curricula we can offer through our national CBA program. These include the **San Francisco AIDS Foundation, UCSF**, **A&PI Wellness Center,** and the **University of Miami**. Additional expert consultants across the three component areas have been identified to participate in webinars, online trainings, boot camps, and regional workshops, and/or provide technical assistance. Please refer to their biographies and specific contributions in Section 4.

D. **Evaluation and Performance Management Plan**

Needs Assessment: To guide the prioritization of information dissemination, training program development, and scale-up of technical assistance, we propose to conduct an initial needs assessment with health departments that are potential recipients of CBA services. We will adopt a mixed methods approach that will include key informant interviews as well as an online survey to assess knowledge of key elements of high-impact HIV prevention and self-efficacy to implement these components. See page N-29 for more details on the development and implementation of this assessment. We are prepared to take a lead role in this effort; however, we are committed to collaborate with other Category A grantees and the CPN to develop survey instruments and interview guides. In addition, we will engage our pool of contacts at CDC-funded health departments in reviewing and piloting the assessment tools.

Process Evaluation

Tracking of Services & Products Provided: We will record all TA and training provision using the CRIS system. All CBA services, activities, products and deliverables that cannot be entered in CRIS (e.g., blog posts, live chats) will be recorded in our internal CBA tracking system.

Evaluation of Implementation: We will employ a mixed methods approach to evaluating the extent to which these services and activities were implemented effectively. Training participants and recipients of TA will be asked to complete a short satisfaction questionnaire as described on pages N-36 and N-37. In-depth TA recipients will also be asked to give feedback periodically throughout TA provision. The faculty and staff involved in providing TA and training will regularly debrief with the leadership team about the implementation of the activities and what might be improved. The online CBA portal will also include feedback mechanisms, including rating buttons at the bottom of each page and an optional survey that will appear once these initial questions are answered.

Monitoring of Proportion of Target Population Served: We will use a range of strategies to track the number of health departments reached. We will use CRIS to record the number of Pull TA requests, and we will keep attendance rosters for all Push TA including sign-in sheets at peer-to-peer mentoring meetings and a roster of live chat participants. Access to informational resources and eLearning courses will be automatically recorded through the online CBA portal. All data sources will include the names of the health departments served. At the end of each project year, we will estimate the number of health departments reached by combining the data sources listed above and removing any duplicates. We will determine the *proportion* of individuals reached based on the number of health departments receiving funding from CDC for high-impact prevention activities.

Completion of CDC-Required Evaluation Activities: The project team will also participate in all data collection and reporting activities as required by CDC, including real-time data entry into CRIS, as noted above, and the submission of progress reports (see pages N-38 and N-39 for more details on these activities).

Outcome Evaluation: We will include several questions in the needs assessment survey described above to establish baseline levels of health department staff perceptions of the accessibility and availability of CBA, and their current level of utilization. This section of the survey will be re-administered at the 2-year and 4-year mark to evaluate the impact of the CBA services and materials provided. In addition, the surveys for TA and training recipients will include questions related to HIP implementation capacity, including changes in knowledge, skills, self-efficacy, and intended use of capacity.

Target Population Engagement: Survey instruments will be reviewed for clarity and usability by a subset of individuals within our pool of contacts at CDC-funded health departments before implementation. Instruments will also be piloted with a small group of CBA recipients before disseminating broadly. To help maintain high response rates, we will ask face-to-face training participants to complete the satisfaction questionnaire while still on-site, and will use a system of follow-up emails and calls to remote CBA recipients (see page N-36 for a description of our follow-up protocol).

Continuous Quality Improvement and Dissemination of Best Practices: The leadership team will continuously monitor all sources of feedback. Feedback and recommendations will be a standing item on this team's meeting agenda so that changes can be determined and implemented quickly. We will convene our CBA providers on an annual basis to provide feedback gathered during our monitoring and evaluation activities and solicit input from this group to enhance the program. Finally, we will be implementing several novel CBA strategies and are committed to publishing evidence on effectiveness of these strategies and best practices.

Work Plan

Purpose and Outcomes

Background: The goal of the Center's CBA program is to **provide evidence-based CBA services to health departments** to improve their ability to conduct high-impact, combination HIV prevention in their jurisdictions, with a particular emphasis on **improving their ability to provide high-impact HIV Testing and Prevention with High-Risk Negative Persons, and to create Policy.** This goal will be achieved by providing free CBA services to health departments, comprised of:

1) **Information** collection, monitoring, synthesis, packaging, and dissemination about HIV Testing, Prevention with High-Risk Negative Persons, and Policy;
2) **Training** for skills development and knowledge transfer, including interactive adult learning opportunities about HIV Testing, Prevention with High-Risk Negative Persons, and Policy; and
3) **Technical assistance** including consultations on delivering state-of-the-science HIV Testing, Prevention with High-Risk Negative Persons, and developing Policy; health department assessments; facilitation of peer-to-peer mentoring; and assistance with implementing online and mobile health (mHealth) tools.

Purpose: The purpose of the Center's CBA Program is to strengthen the capacity of the national HIV prevention workforce to optimize health departments' planning and implementation of sustainable interventions and strategies for high-impact HIV Testing, Prevention with High-Risk Negative Persons, and Policy.

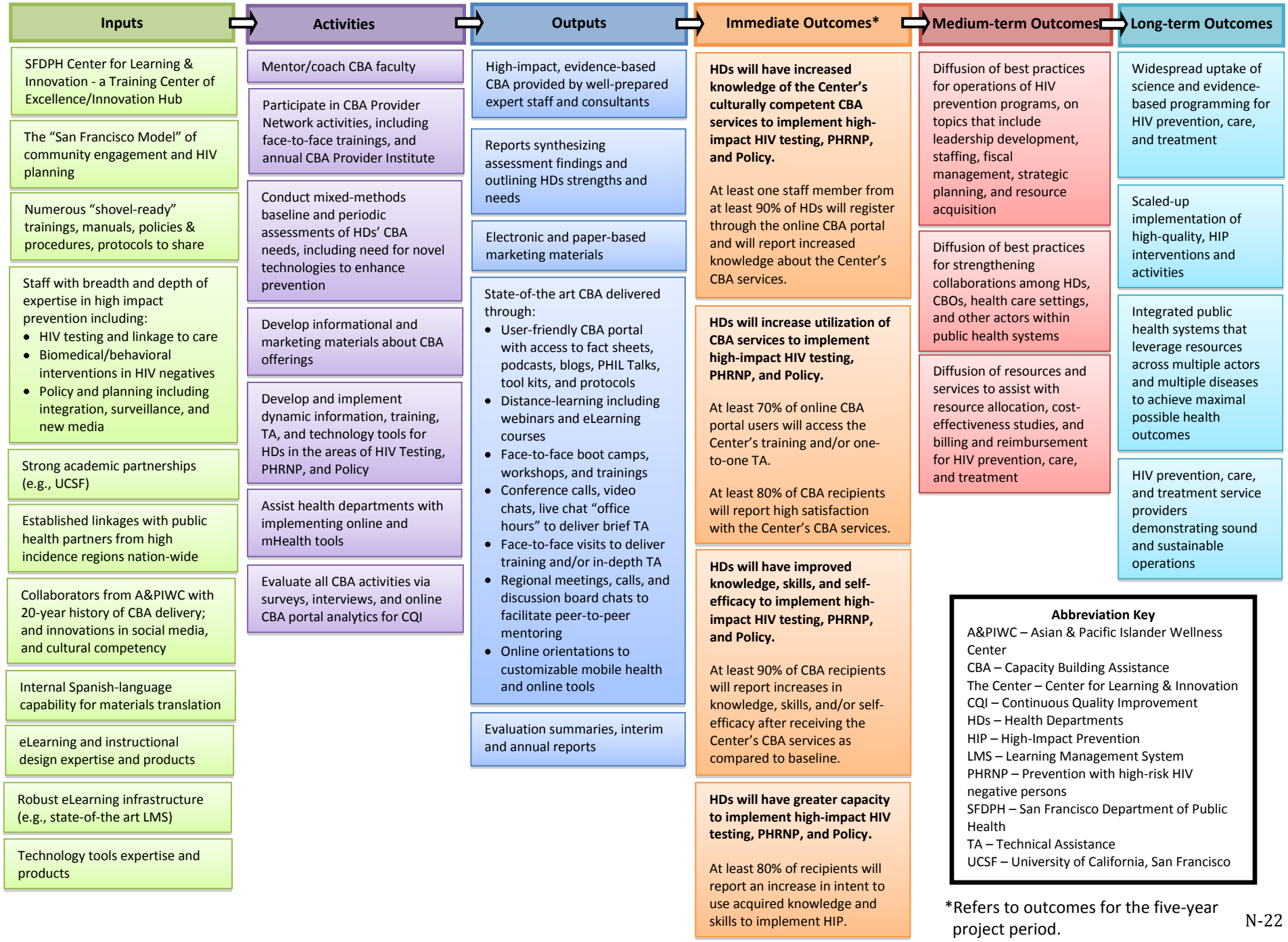
Outcomes: The Center will contribute to the overall achievement of CDC's anticipated medium- and long-term outcomes for the CBA network. These outcomes are outlined in the logic model figure on page N-22. In order to contribute to these outcomes, the Center will utilize inputs, activities, and outputs to achieve shorter-term, five-year outcomes. These outcomes will be measured in numerous ways. First, health department staff will register in the Center's online CBA portal, where they may access toolkits, fact sheets, blog posts, discussion boards, PHIL Talks, webinars, and peer-to-peer information sharing tools. Through the portal, the Center's staff will be able to track the numerous resources accessed by portal users. Second, all CBA services will be entered into CRIS so the Center's staff will be able to generate reports about service utilization. Third, evaluation tools described later in this document will assess recipients' satisfaction; increases in knowledge, skills, and self-efficacy; and intent to use acquired knowledge and skills. Below is a table outlining the five-year outcomes the Center will achieve through its CBA services and products.

i. Five Year Overview and Project Work Plan

Five-Year Outcome	Performance Measure	Description
Health departments will have increased knowledge of the Center's culturally competent CBA services to implement high-impact HIV Testing, Prevention with High-Risk Negative Persons, and Policy.	At least one staff member from at least 90% of health departments will register through the online CBA portal and will report increased knowledge about the Center's CBA services.	Through the Center's electronic and paper marketing efforts, outreach calls, and information dissemination (e.g., toolkits, PHIL Talks, blog posts, fact sheets, and e-newsletters) health departments will learn about the Center's CBA services. Each marketing and information resource will link to the Center's CBA portal registration page so that health departments can access the portal and all of its resources.
Health departments will increase utilization of CBA services to implement high-impact HIV Testing, Prevention with High-Risk Negative Persons, and Policy.	At least 70% of online CBA portal users will access the Center's training and/or one-to-one TA.	Users of the online CBA portal will have access to numerous training resources. Users will also have access to faculty bios and "office hours" (live chat), which will prompt them to request more in-depth training and TA services from the Center. We anticipate additional CBA requests through non-portal users via CRIS.
	At least 80% of CBA recipients will report high satisfaction with the Center's CBA services.	Through the initial and ongoing assessments of health departments the Center will provide responsive CBA services and products that align with health department priorities. This responsiveness will lead to a high level of recipient satisfaction. The Center will administer satisfaction surveys after users access information via the online CBA portal, participate in trainings, and/or receive TA. The Center will use this data for continuous quality improvement (CQI), which will result in increasing satisfaction with our services over time.
Health departments will have improved knowledge, skills, and self-efficacy to implement high-impact HIV Testing, Prevention with High-Risk Negative Persons, and Policy.	At least 90% of CBA recipients will report increases in knowledge, skills, and self-efficacy after receiving the Center's CBA services as compared to baseline.	The Center's CBA expert staff and faculty will provide high-impact, evidence-based CBA. As a health department offering CBA to our peers, the Center is in a unique position to provide information, training, TA, and technology tools that increase recipients' knowledge, skills, and self-efficacy.
Health departments will have greater capacity to implement high-impact HIV Testing, Prevention with High-Risk Negative Persons, and Policy.	At least 80% of recipients will report an increase in intent to use acquired knowledge and skills.	The Center will provide support to health departments to implement HIP. As part of a health department that has implemented HIP strategies, the Center understands the challenges of shifting priorities, obtaining community stakeholder feedback, and implementing new strategies in a time of fluctuating resources. The Center will develop CBA services and products that are useful to and utilized by health departments.

Conditions and statement of need: There is a pressing need to bolster the capacity of health departments around the country to implement CDC's call for High-Impact Prevention (HIP), aligned with the National HIV/AIDS Strategy. The Center proposes the following work plan to increase and strengthen the capacity of health departments throughout the United States and its territories. This includes strategies to increase identification of people infected with HIV, link and retain HIV-positive individuals in treatment and care, and reduce HIV transmission in high-prevalence populations. This five-year work plan will provide health departments with responsive, customized, state-of-the-science CBA services focused on three HIP areas: **HIV Testing**, **Prevention with High-Risk HIV-Negative Persons**, and **Policy**. The Center will involve subject matter experts from within the Center's CBA faculty, external CBA providers, and partners at CDC to inform the development of new materials, including curricula for training. We present the logic model figure for the five-year project period on the following page. This figure outlines **inputs**, **activities**, and **outputs** to achieve the **outcomes** listed above, which will strengthen health departments' abilities to provide High-Impact HIV Testing, Prevention with High-Risk HIV-Negative Persons, and develop Policy.

Logic model follows on the next page.


Inputs
SFDPH Center for Learning & Innovation - a Training Center of Excellence/Innovation Hub
The "San Francisco Model" of community engagement and HIV planning
Numerous "shovel-ready" trainings, manuals, policies & procedures, protocols to share
Staff with breadth and depth of expertise in high impact prevention including:
• HIV testing and linkage to care
• Biomedical/behavioral interventions in HIV negatives
• Policy and planning including integration, surveillance, and new media
Strong academic partnerships (e.g., UCSF)
Established linkages with public health partners from high incidence regions nation-wide
Collaborators from A&PIWC with 20-year history of CBA delivery; and innovations in social media, and cultural competency
Internal Spanish-language capability for materials translation
eLearning and instructional design expertise and products
Robust eLearning infrastructure (e.g., state-of-the art LMS)
Technology tools expertise and products
Activities
Mentor/coach CBA faculty
Participate in CBA Provider Network activities, including face-to-face trainings, and annual CBA Provider Institute
Conduct mixed-methods baseline and periodic assessments of HDs' CBA needs, including need for novel technologies to enhance prevention
Develop informational and marketing materials about CBA offerings
Develop and implement dynamic information, training, TA, and technology tools for HDs in the areas of HIV Testing, PHRNP, and Policy
Assist health departments with implementing online and mHealth tools
Evaluate all CBA activities via surveys, interviews, and online CBA portal analytics for CQI
Outputs
High-impact, evidence-based CBA provided by well-prepared expert staff and consultants
Reports synthesizing assessment findings and outlining HDs strengths and needs
Electronic and paper-based marketing materials
State-of-the art CBA delivered through:
• User-friendly CBA portal with access to fact sheets, podcasts, blogs, PHIL Talks, tool kits, and protocols
• Distance-learning including webinars and eLearning courses
• Face-to-face boot camps, workshops, and trainings
• Conference calls, video chats, live chat "office hours" to deliver brief TA
• Face-to-face visits to deliver training and/or in-depth TA
• Regional meetings, calls, and discussion board chats to facilitate peer-to-peer mentoring
• Online orientations to customizable mobile health and online tools
Evaluation summaries, interim and annual reports
Immediate Outcomes*
HDs will have increased knowledge of the Center's culturally competent CBA services to implement high-impact HIV testing, PHRNP, and Policy.
At least one staff member from at least 90% of HDs will register through the online CBA portal and will report increased knowledge about the Center's CBA services.
HDs will increase utilization of CBA services to implement high-impact HIV testing, PHRNP, and Policy.
At least 70% of online CBA portal users will access the Center's training and/or one-to-one TA.
At least 80% of CBA recipients will report high satisfaction with the Center's CBA services.
HDs will have improved knowledge, skills, and self-efficacy to implement high-impact HIV testing, PHRNP, and Policy.
At least 90% of CBA recipients will report increases in knowledge, skills, and/or self-efficacy after receiving the Center's CBA services as compared to baseline.
HDs will have greater capacity to implement high-impact HIV testing, PHRNP, and Policy.
At least 80% of recipients will report an increase in intent to use acquired knowledge and skills to implement HIP.
Medium-term Outcomes
Diffusion of best practices for operations of HIV prevention programs, on topics that include leadership development, staffing, fiscal management, strategic planning, and resource acquisition
Diffusion of best practices for strengthening collaborations among HDs, CBOs, health care settings, and other actors within public health systems
Diffusion of resources and services to assist with resource allocation, cost-effectiveness studies, and billing and reimbursement for HIV prevention, care, and treatment
Long-term Outcomes
Widespread uptake of science and evidence-based programming for HIV prevention, care, and treatment
Scaled-up implementation of high-quality, HIP interventions and activities
Integrated public health systems that leverage resources across multiple actors and multiple diseases to achieve maximal possible health outcomes
HIV prevention, care, and treatment service providers demonstrating sound and sustainable operations
Abbreviation Key
A&PIWC – Asian & Pacific Islander Wellness Center
CBA – Capacity Building Assistance
The Center – Center for Learning & Innovation
CQI – Continuous Quality Improvement
HDs – Health Departments
HIP – High-Impact Prevention
LMS – Learning Management System
PHRNP – Prevention with high-risk HIV negative persons
SFDPH – San Francisco Department of Public Health
TA – Technical Assistance
UCSF – University of California, San Francisco
*Refers to outcomes for the five-year project period.

Inputs into the Center's CBA program, as outlined in the logic model figure, are described in greater detail below.

The Center for Learning and Innovation, within SFDPH's Population Health Division, is a new center built on the Division's long history providing HIV prevention CBA, both domestically and internationally. See page N-12 for more background information on the Center.

The "San Francisco Model" of community engagement and HIV planning: The SFDPH has a long history of successful and innovative combination HIV prevention and care strategies and strong community engagement efforts, which has led to an endemic (vs. epidemic) state of HIV among MSM, a low endemic state of HIV among injection drug users, and comprehensive efforts to understand and address the HIV epidemic among transgender females. The SFDPH has been partnering with the HIV Prevention Planning Council (the local community planning group) to prioritize HIV prevention resources in San Francisco for nearly 20 years. Between 2010 and 2011, the SFDPH initiated a reprioritization of HIV prevention resources. Over the course of a year SFDPH worked closely with the HIV Prevention Planning Council to review HIV prevention science and local epidemiological data. Relations between SFDPH and the Council were challenged by the paradigm shift the SFDPH proposed—to focus on HIP using an upstream, structural approach to HIV prevention and a combination of interventions that reduce community-level risk for HIV. Grounded in the shared principle that community values + science = success the SFDPH and the HIV Prevention Planning Council found common ground and developed the following strategy: 1) Scale-up of a continuum of services for HIV-positive people, from initial diagnosis through accessing and maintaining care and treatment. This scale-up includes increased HIV testing (both targeted community-based testing, as well as routine screening in clinical settings), expanded partner services, and augmentation of existing linkage to care, re-engagement in care, and treatment adherence efforts. 2) Concentrated, scaled-down behavioral interventions for HIV-positive and HIV-negative individuals in high-prevalence groups (i.e., MSM, Black MSM, Latino MSM, and transgender females), with the recognition that the benefits of this new upstream approach will only be realized if community and individual norms and skills for practicing safer sex and other harm reduction approaches are promoted. 3) Maintenance of existing

The Center's Core CBA Values

- **Collaborative.** CBA services will facilitate a community of learning and learners.
- **Customizable.** CBA services will be tailored and will be culturally and linguistically appropriate.
- **Responsive and timely.** CBA services will respond directly to the strengths and needs of the recipient and will be delivered in a timeframe that allows use of the products and information to address immediate challenges.
- **Evidence-based and data-driven.** CBA services will provide recipients with "state-of-the-science" information, training, TA, and technology tools grounded in the latest evidence and data.
- **Embracing paradigm shifts**. CBA services will adapt to new evidence, data, and contexts to provide recipients with knowledge and skills to implement innovative strategies.
- **High-impact.** CBA services will provide recipients with information and tools to develop scalable, cost-effective interventions with demonstrated potential to reduce new HIV infections.

efforts in areas where San Francisco has substantial success: syringe access and disposal, perinatal prevention, condom access, and PEP. The Center is strategically positioned to leverage the SFDPH's years of experience with community engagement, community planning, and successful HIV prevention strategy development, along with the expertise within the SFDPH's Population Health Division, to provide peer-to-peer support to other health departments.

Numerous "Shovel-ready" materials: The Center's CBA Program has a number of existing resources, including trainings, manuals, templates, policies & procedures, and protocols to share with health departments, including:

- Linkage, Navigation, and Comprehensive Services (LINCS) Program Protocols, which includes information on embedding health department linkage to care and partner services staff in high-volume community based testing facilities; using surveillance data to identify out-of-care PLWH to triage for navigation services; program descriptions; and counseling materials.
- PrEP and PEP implementation materials, including protocols (eligibility screening, HIV testing, monitoring for toxicity, visit scheduling), consent forms, and counseling questionnaires for adherence and sexual behavior assessment.
- Policies for providing opt-out HIV testing in healthcare settings, including consent practices, provision of test results, and linkage to care.
- Training for community-based HIV testing programs, including training in counseling skills and Stages of Change; rapid test proficiencies for point-of-care rapid test technologies, including various HIV testing technologies and the rapid hepatitis C test; training in integrating STD and viral hepatitis testing; and training in prioritizing high-prevalence populations for testing based on local epidemiology.
- Policies, procedures, and CQI materials for community-based HIV testing and integrated HIV/hepatitis C testing, including confidentiality protocols, consent forms, data collection instruments, lab slips, testing laboratory logs, training requirements, and specimen collection and handling.
- Program guidelines and policies for syringe access and disposal services, including authorization requirements, community and police relations policies, and requirements for supplies and disposal services.

Staff with breadth and depth of expertise in HIP: Our CBA faculty has a wide breadth of expertise, spanning the three areas of HIV testing, prevention with high-risk negative persons, and policy. This expertise is illustrated in depth in the CVs and bios found in Section 4.

Strong academic partnerships: Drs. Fuchs and Bacon are faculty in the Department of Medicine at UCSF and have strong ties to UCSF collaborators who will play an important role in implementing and evaluating our CBA strategies. In addition, the SFDPH has partnered with the University of Miami to implement the first PrEP demonstration project nation-wide. See page N-11 for more details on our academic partnerships.

Established linkages with public health partners from high incidence regions nationwide: The Center has close relationships with numerous public health partners, including health departments, policy groups, CBA providers, and CBOs. Partners are described on pages N-10 and N-11.

Collaborators from A&PI Wellness Center: A&PI Wellness Center has a 20-year history of delivering CBA to health departments and CBOs. They have innovated the use of social media for HIV prevention and have a long track record of strengthening HIV prevention providers' cultural competency to deliver services to transgender individuals and people of color. As a long-standing provider of CDC-funded HIV prevention CBA, A&PI Wellness Center will provide consultation to the Center on the implementation of the CBA program, including advising on the development of program policies and the faculty kickoff orientation event.

Internal Spanish-language capability for materials translation: The Center has capacity to translate materials into Spanish to support health departments' efforts to reach monolingual Spanish-speaking Latinos at risk for and living with HIV. The SFDPH has staff who have experience translating HIV prevention materials into Spanish and has a history of tailoring efforts to reach Latinos at risk for HIV, particularly MSM and transgender females (e.g., the Latino Action Plan).

eLearning and instructional design expertise and products: The Center's staff are instructional design experts, having developed various training curricula for in-person and eLearning courses and trainings. In addition to the online risk reduction and adherence counseling training and course on the UNAIDS Good Participatory Practice guidelines mentioned on page N-7, Center staff have developed numerous capacity building programs for HIV researchers in the areas of HIV vaccine development, immunology, laboratory methods, statistics, manuscript writing, and grant writing. The Center also develops the curriculum for the Summer HIV/AIDS Research Program, an immersion experience for students from underrepresented backgrounds, and redesigned the curriculum for the Basic Counselor Skills Training, the training required for HIV test counselors working in non-clinical settings in California.

Robust eLearning infrastructure: The Center maintains a state-of-the-art learning management system and is experienced in using online portals to facilitate learning communities. We have established partnerships with technology companies that assist in designing and implementing eLearning programs.

Technology tools expertise and products: The Center has an established relationship with a health information technology company (RDE Systems) to provide technology tools expertise and products. For more information on these tools, see page N-9.

Outputs and supporting activities for the Center's CBA program, as outlined in the logic model figure, are described in greater detail below.

Output: High-impact, evidence-based CBA provided by well-prepared expert staff and consultants.

Supporting Activities:

Mentor/coach CBA faculty: The Center will ensure that CBA core staff and consulting faculty receive mentoring and coaching to provide high-quality, high-impact CBA services to health departments. This will include careful vetting of new hires for experience in training and mentoring, experience with health departments, and experience with HIV prevention; an initial orientation for all CBA team members; review of monitoring and evaluation materials from individual activities delivered to recipients; a semiannual progress meeting; and annual individual performance reviews. See page N-29 for a description of the kick-off event.

Participate in CBA Provider Network activities, including face-to-face trainings, and annual CBA Provider Institute: The Center will engage with other CBA providers through trainings, webinars, conference calls, e-mails, and in-person meetings to build internal capacity as well as exchange information and coordinate with other CBA providers. See more details on pages N-38 and N-39.

Output: Reports synthesizing assessment findings and outlining health departments' strengths and needs.

Supporting Activity:

Conduct mixed-methods baseline and periodic assessments of health departments' CBA needs, including need for novel technologies to enhance prevention: A baseline survey will be conducted to assess knowledge, skills, and self-efficacy. Assessment will be conducted in the first, second, and fourth years to understand health departments' staff members' knowledge, attitudes, skills, and self-efficacy related to planning, implementing, and evaluating HIP activities and to determine CBA needs support HIP in various jurisdictions. The baseline survey and periodic assessments will inform the development of Center's CBA offerings for health departments. A description of the baseline assessment is on page N-29.

Output: Electronic and paper-based marketing materials.

Supporting Activity:

Develop informational and marketing materials about CBA offerings: The Center will create paper and electronic marketing materials to send to health departments so they are aware of the CBA offerings, have the Center's contact information, and have links to electronic resources (e.g., PHIL Talks, "State of the Science" blog, podcasts, discussion board, etc.) on the Center's website/online CBA portal. These materials will take the form of brochures, emails, and newsletters. See more details on page N-31.

Outputs: State-of-the art CBA including information dissemination, training, and technical assistance.

Supporting Activities:

Develop and implement dynamic training, TA, and information for health departments: The Center will design and implement state-of the art CBA as described on pages N-4 to N-9.

Output: Evaluation summaries, interim and annual reports.

Supporting Activity:

Evaluate all CBA activities for CQI: The Center's staff will evaluate all CBA activities via surveys, interviews, and online CBA portal analytics to continuously improve CBA services and ensure we are achieving the outcomes outlined in this work plan. We will solicit feedback from health department on an ongoing basis. When engaging with health departments to provide in-depth TA, we will obtain health department satisfaction information throughout the process of developing the scope or work, the pilot/demonstration phase, full-scale implementation, and follow-up. More details about the evaluation plan can be found on pages N-17, N-18, and N-36 to N-41.

ii. Year 1 Detailed Work Plan

Program Strategies

The Center will deliver free CBA services to health departments. These CBA services will be comprised of 1) information collection, monitoring, synthesis, packaging, and dissemination; 2) training for skills development; and 3) technical assistance including consultations, facilitation of peer-to-peer mentoring, and assistance with implementing mobile health and online tools. The Center's CBA services and products will focus on the program components of HIV Testing, Prevention with HIV with High-Risk Negative Persons, and Policy.

In the first year, the Center will engage in a Start-Up Phase, followed by an Implementation Phase. The Monitoring, Evaluation, and Compliance Phase will be ongoing throughout the entire first year and throughout the five-year project period. A timeline summarizing key activities can be found on page N-42.

Phase I: Start-Up
The start-up phase will involve all activities necessary to develop a system of excellent CBA provision.

CBA Systems Development: Although many key personnel for the CBA Program are already working within SFDPH, including the CBA Program Director and Manager, the Center will need to hire some additional staff, including CBA Specialists, a Communications Coordinator, and a Program Assistant. Additionally, in collaboration with A&PI Wellness Center, the Program Manager will spearhead efforts to establish all policies and procedures for the Center's CBA program, and coordinate an orientation to CRIS for the core CBA team. Another key activity during this phase is to prepare the online CBA portal for launch. The Program Manager will work with our web technology partner, Monarch Media, to develop this portal, including integrating it with our existing learning management system (LMS), and adding social networking features such as user profiles, secure user-to-user messaging, and discussion forums. The Program Manager will also work with Monarch to create an online training and events calendar; a page with links to key references, CDC resources, and CBA providers; and pages for electronic materials, such as PHIL Talks, the "State of the Science" blog, podcasts, and videos. The Program Assistant will conduct a complete inventory of all PowerPoint presentations,

videos, manuals, and other relevant "shovel-ready" (i.e., existing and ready to share) documents and share them with the Executive Committee for review. Upon approval, the Program Assistant will upload these resources to the online CBA portal.

Initial Assessment of Health Departments: The Evaluation Specialist, in close collaboration with the AIDS Education and Training Centers (AETC) National Evaluation Center at UCSF, will spearhead the development, piloting, and launch of an initial assessment of health departments' strengths and needs and assemble a report of findings. This survey tool will be used to assess health departments' knowledge, skills, and self-efficacy related to high-impact HIV Testing, Prevention with High-Risk Negative Persons, and Policy; their CBA needs; and what they are doing well that should be disseminated to other health departments. The survey will also include questions to assess technology needs, which will guide our development of technology tools with RDE Systems and other possible vendors. As the first step in development of this assessment, the Evaluation Specialist and AETC National Evaluation Center will develop and administer a key informant interview instrument with staff from high-prevalence jurisdictions to collect initial, in-depth information on health department needs, strengths, and priorities. Using this information, the Evaluation Specialist and AETC National Evaluation Center will draft a survey tool and pilot it with several health departments. Based on initial feedback, the Evaluation Specialist and AETC National Evaluation Center will refine the questionnaire. The Communications Coordinator will work with CDC, CPN, and/or NASTAD to obtain contact information for each CDC-funded health department and disseminate the survey tool. If allowed, health department staff completing the survey will be entered into a raffle (e.g., for a tablet computer) to bolster response rates. We have used this strategy with much success to boost response rates for other program assessments. Any health departments not responding within the requested time frame will receive reminder emails and follow-up calls from the Program Assistant. After collecting all data, the Evaluation Specialist and AETC National Evaluation Center will synthesize the insights gathered, including an outline of prioritized health departments' CBA needs, and share the report with the CBA Providers Network to disseminate to other CBA providers. These assessment activities will inform the development of our educational activities, including webinars, boot camps, and health summits; and will help identify the highest priority needs for online and mobile health tools.

CBA Faculty Development: The Center will also use the Start-Up Phase to prepare faculty to provide responsive, evidence-based, and properly documented CBA through a kickoff Orientation and Training event. This event will feature a presentation and discussion about cultural responsiveness led by Dr. Toni Rucker, Director of Health Equity, Cultural Competency, and Workforce Development at SFDPH. The Evaluation Specialist, in collaboration with the AIDS Education and Training Centers (AETC) National

Orientation and Training Event Sample Agenda

- Policies and procedures for responding to requests, communicating with CBA recipients, and completing documentation (Sheth)
- CRIS orientation (Sheth)
- Tips for providing excellent customer service (Sheth)
- Cultural responsiveness: Tailoring HIV prevention to local epidemics (e.g., populations affected, rural vs. urban, funding climate, healthcare delivery structure) (Rucker)
- Effective mentoring and coaching models (Fuchs)

Evaluation Center, will develop and implement a survey to measure changes in faculty's level of knowledge, skills, and self-efficacy in providing CBA to other health departments.

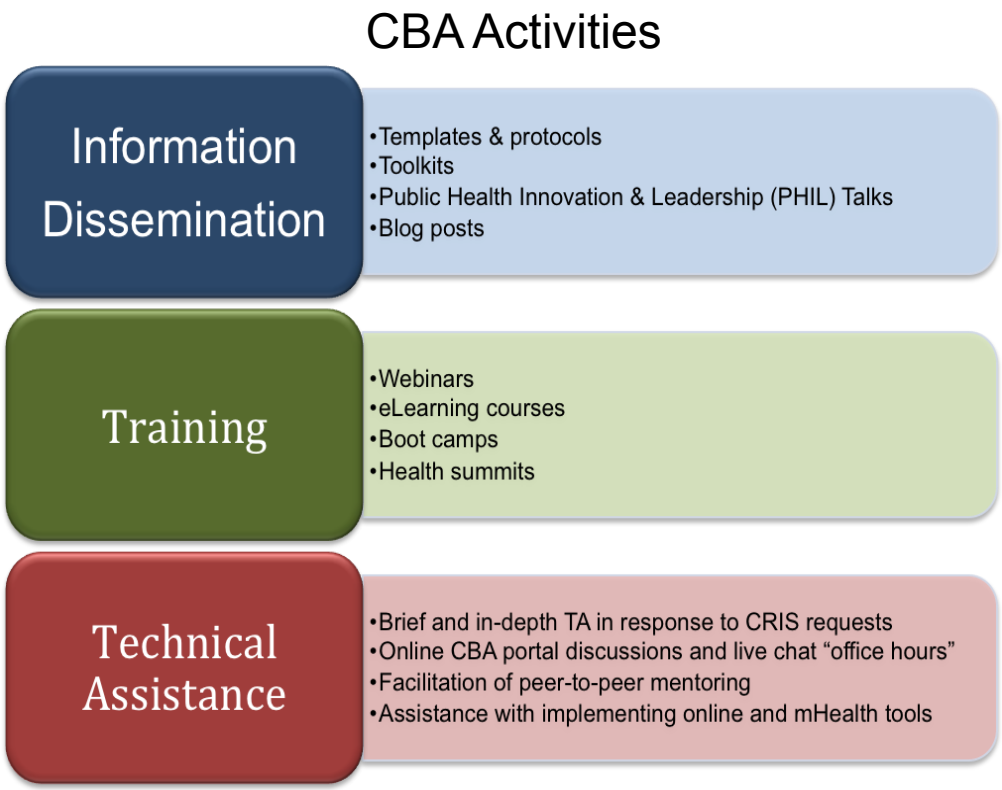
The table below summarizes the outcome, objectives, and activities for Phase I: Start-Up.

Phase I Outcome: Complete all start-up activities and be ready to provide a full complement of CBA that is responsive to health department's needs, by August 1, 2014.		
Objective 1: CBA Systems Development ***By August 1, 2014, have all of the Center's CBA staff and systems (e.g., policies and procedures, online CBA portal, etc.) in place.***	**Primary SFDPH Staff Responsible**	**Collaborators and Partners**
a. Hire any vacant positions, by May 15, 2014.	Director, Program Manager	
b. Orient existing and new CBA staff to the CRIS system, by June 1, 2014.	Program Manager	Implementation Specialist (A&PI Wellness)
c. Establish all policies and procedures for the Center's CBA program, by July 1, 2014.	Director, Program Manager	Implementation Specialist (A&PI Wellness)
d. Develop online CBA portal, by July 31, 2014.	Program Manager	Monarch Media
e. Conduct a complete inventory of existing resources and upload them to a designated area of the website, by July 31, 2014.	Program Assistant	
Objective 3: Initial Assessment of Health Departments ***By July 15, 2014, gather baseline data regarding knowledge, skills, and self-efficacy regarding HIP from all health departments.***		
f. Develop a key informant interview instrument and conduct interviews with at least 10 health department staff, by May 1, 2014.	Evaluation Specialist	AETC National Evaluation Center
g. Develop and pilot-test an initial assessment tool, by May 15, 2014.	Evaluation Specialist	AETC National Evaluation Center
h. Request health department email and mailing addresses from CPN, NASTAD, and other sources, by May 15, 2014.	Communications Coordinator	
i. Revise assessment tool based on pilot test feedback and send to all health departments, by May 30, 2014.	Evaluation Specialist, Communications Coordinator	
j. Email and call all health departments that have not submitted the assessment to remind them to submit it, by May 30, 2014 and by June 15, 2014.	Program Assistant	
k. Create report synthesizing data and share with CPN, by July 15, 2014.	Evaluation Specialist	AETC National Evaluation Center
Objective 2: CBA Faculty Development ***By August 1, 2014, the Center's staff and consulting faculty will report increased knowledge, skills, and self-efficacy to provide high-impact CBA after attending the Center's CBA Program Orientation and Training Event and receiving orientation/training.***		
l. Hold Orientation and Training Event, by July 15, 2014.	Program Manager	
m. Conduct survey with faculty to assess changes in knowledge, skills, and self-efficacy, by July 31, 2014.	Evaluation Specialist	

Phase II: Implementation

The implementation phase encompasses all development and provision of CBA services. The Center will provide a complementary mix of information, training, and TA, tailored according to the needs expressed by health departments in the initial assessment.

Marketing CBA Program and Outreach to Health Departments: The Communications Coordinator will work with other members of the core CBA team to develop outreach materials, including an introductory email and paper brochure that describe the Center's CBA offerings and include a link to register for the online CBA portal, and will distribute these materials. If allowed, the Center will incentivize portal registration by hold a raffle among those who register. In addition, the Communications Coordinator and Program Assistant will call health departments that have no yet registered to confirm they received the email and brochure and to remind them to register for the portal. The Communications Coordinator and Program Assistant will also work together to organize and promote an online monthly orientation for the CBA portal. The orientation will provide instruction on how to sign up and navigate the portal as well as showcase items that are likely to draw in users, such as the PHIL Talks and eLearning courses. The Communications Coordinator will further engage health departments by developing and sending a semiannual newsletter highlighting the Center's CBA products, services, and faculty. The Communications Coordinator will also submit descriptions of all learning opportunities for inclusion in the CDC Training Events Calendar (TEC).



State-of-the-Science Information Development & Dissemination: The Curriculum Development Specialist will work with Subject Matter Expert Faculty Leads to assemble toolkits and to identify templates, protocols, fact sheets, white papers, and other informational resources that can be readily shared with other health departments. The Communications Coordinator will oversee

the development of PHIL Talks, including identifying faculty to give the talks, coordinating logistics with help from the Program Assistant, and liaising with the Alan Zucker Enterprises throughout post-production. The Communications Coordinator will also coordinate the production of blog posts, engaging with Faculty who will provide content expertise. Once finalized, the Communications Coordinator will post informational resources to the online CBA portal.

State-of-the-Science Training Development & Provision:

The Communications Coordinator will organize and promote a monthly webinar, each of which will feature Subject Matter Expert Faculty from the Center or a partnering organization. A listing of planned webinar topics and faculty are shown on the right. Based on the priorities expressed in the initial assessment, the Executive Steering Committee will select one topic to develop into an eLearning course during the first year. The Curriculum Development Specialist will lead the development of this course, using existing content such as PowerPoint slides to draft a storyboard for an interactive online course, and engaging Subject Matter Expert Faculty in reviewing the draft content. One approved, the Curriculum Development Specialist will work with SweetRush to program the course and with Monarch Media to deploy the finished course on the CBA portal. The Deputy Director will lead the planning and implementation of the two-day interactive Boot Camp on PEP and PrEP. A major goal of the Boot Camp is for participants to develop concrete plans for program implementation in their jurisdictions. Participants will be expected to prepare in advance by conducting an inventory of local opportunities and challenges regarding PrEP and/or PEP implementation so that they can focus on addressing these with experts during the Boot Camp (see figure to the right for the draft agenda). The Deputy Director will convene working group including internal Subject Matter Expertise Faculty, and partners from University

Webinar Topic	Faculty
HIV Testing	
Advances in HIV Testing Technologies	Pandori
The role of the Academic Detailer in influencing provider testing and treatment practices	Bacon
Enhanced HIV Testing and Linkage to Care from the Emergency Department: Make it PHAST - Positive Health Access to Services & Treatment	Hare, Jones
Prevention with High-Risk HIV-Negative Persons	
Do We Need a PrEP Rally? Motivating Uptake of an Effective HIV Prevention Intervention for HIV Negative Persons at High-Risk	Liu, Cohen
Engaging the Transgender Community – What Works?	Rapues, Wilson
Substance Use and HIV: Targeting Drivers of HIV Infection	Coffin
Policy	
Data Visualization in HIV Surveillance & Epidemiology	McFarland, Raymond
The Affordable Care Act: What Does it Mean for HIV Prevention?	Mulhern-Pearson, Smith
Partnering with Police to Support Syringe Access & Disposal	Loughran, Huriaux

PrEP/PEP Boot Camp Draft Agenda

- From Science to Clinic: Lessons Learned from PEP Programs and PrEP Demonstration Projects
- PrEP for MSM; PrEP for women
- PrEP and PEP Counseling Role-Play Practice
- HIV Testing Strategies for PrEP Programs
- Workshop: developing a PrEP/PEP plan for your jurisdiction
- Community Relations

of Miami, UCSF, and San Francisco AIDS Foundation. This working group will be responsible for setting the agenda, and selecting topics and speakers. The Program Assistant will manage logistics for this event, including securing space, ordering food, and preparing materials. Conference Solutions will be responsible for booking travel for faculty from University of Miami and visiting health department staff. One of the two CBA Specialists will coordinate efforts with the AIDS Education Training Centers and the UCSF Bay Area Perinatal AIDS Center to produce a reproductive health summit, entitled "Toward Elimination of Sexual and Perinatal HIV Transmission: Integrating Reproductive Health Care into Public Health and Primary Care Settings." This event will coincide with a national conference such as the CDC HIV prevention conference or the US Conference on AIDS (USCA). The draft agenda for this summit is shown on the left. If needed, the CBA Specialists will also provide training on CDC's Effective Interventions to health departments, as health departments may need to provide TA to CBOs and health care organizations in their region to support the implementation of Effective Interventions. Members of our CBA team are skilled in HIV testing and prevention interventions with high-risk HIV-negative persons. These include CTR (Counseling, Testing, and Referral), Partner Services, d-up: Defend Yourself!, RESPECT, and Personalized Cognitive Counseling. The CBA Specialists can also be trained as trainers in other effective interventions as needed, such as ARTAS (Anti-Retroviral Treatment and Access to Services). See www.effectiveinterventions.org for more information on these interventions.

Reproductive Health Summit Draft Agenda

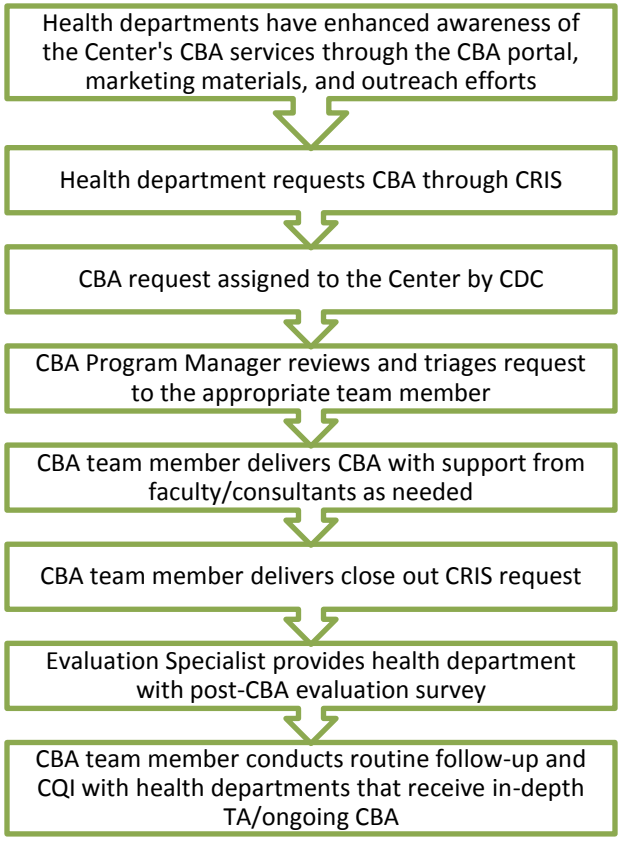
- A Framework for the Elimination of Sexual and Perinatal HIV Transmission: Lessons learned from perinatal HIV
- Condoms, Babies, ARVs, PrEP: Oh My! Sexual and Reproductive Health Clinical Update
- Identifying Knowledge, Templates and Resources to Implement Best Practices
- Facilitators and Barriers to Implementation

State-of-the-Science Technical Assistance: The Program Manager will be responsible for routing CRIS requests to the appropriate staff member(s), ensuring that staff responds to these requests within 72 hours, following up with assigned staff to ensure they close out the requests in CRIS, and coordinating with the Evaluation Specialist to deliver the satisfaction survey (see figure on following page for CRIS request workflow). Depending on the topic area, the Program Manager will route the request to the CBA Specialists, the Deputy Director, and/or Subject Matter Expertise Faculty. Requests for brief TA (under four hours) will be fulfilled through online chats, phone calls, and video conferencing. More in-depth TA (four hours or longer) will likely involve ongoing phone and/or electronic communications and, in some cases, in-person visits to

Estimate of TA Demand

Based on the CDC's report on CBA services in 2012, approximately 17% of the 674 formal TA and training requests (or 112) were made by health departments. Given that there were five health department CBA providers in 2012, we estimate that each of these providers received **approximately 2 requests per month through CRIS**. In addition, the Center's faculty members currently receive at least 2-3 informal requests for TA per month. Through our marketing efforts, we anticipate doubling this number to **at least 5 direct requests per month** *(Note: Potential recipients will be asked to submit formal requests through CRIS)*. Thus, our planning accounts for fulfillment of **approximately 7 TA requests per month**, most of which will be for brief TA (four hours or less) and a few of which will be for in-depth TA (more than four hours).

the recipient health department. We will provide Push TA in addition to the Pull TA requests received through CRIS. The regular live chat "office hours" are a hybrid of Push/Pull TA. The Communications Coordinator will organize three "office hours" sessions per month, featuring Subject Matter Expert Faculty. One session will be held each month for each of the three prevention areas (i.e., Testing, Prevention with High-Risk Negative Persons, and Policy). The TA provided through these sessions will be very brief in nature, and faculty will ask recipients to submit requests through CRIS for more in-depth assistance. Another major component of our Push TA offerings is peer-to-peer mentoring that utilizes a blended learning approach. One of the CBA Specialists will be responsible planning the first regional peer-to-peer mentoring meeting, which will be held in San Francisco, and host representatives from Bay Area health departments. This meeting will be planned in close collaboration with our partners at the Alemeda County Department of Public Health. After the initial kick-off meeting, the CBA Specialist will host monthly live chat sessions on the online CBA portal to facilitate on-going mentoring between these departments. Building on lessons learned from the first cohort, the CBA Specialist will launch a second peer-to-peer mentoring cohort with Southeast US health departments, including a kick-off meeting and series of monthly chats. Another form of Push TA is assistance with implementation of online and mobile health tools. During the first year, we will roll out the online, customizable HIV prevention, care, and treatment services resource guide platform. The Center will pilot this platform with two health departments. One of the CBA Specialists will facilitate the relationship between RDE Systems and the health departments as part of this pilot, including coordinating an orientation to the platform an how to enter local services, following up with the health departments to ensure the project is moving forward, and troubleshooting any issues encountered.



The table below summarizes the outcome, objectives, and activities for Phase II: Implementation of CBA services.

Phase II Outcome: Provide a full complement of CBA services and products, including information development and dissemination, training, and TA that are responsive to health departments needs from August 1, 2014 through the project period.		
Objective 4: Marketing CBA Program and Outreach to Health Departments ***By March 31, 2015, reach out to all jurisdictions funded by CDC for HIV prevention to introduce the Center's CBA program and market the CBA services.***	**Primary SFDPH Staff Responsible**	**Collaborators and Partners**
a. Create and disseminate an introductory email and brochure highlighting CBA services and inviting health departments to register on the online CBA portal by August 1, 2014.	Communications Coordinator	
b. Host a monthly CBA portal orientation session, between August 1, 2014 and March 31, 2015.	Communications Coordinator, Program Assistant	
c. Develop and disseminate two newsletters promoting CBA services, between August 1, 2014 and March 31, 2015.	Communications Coordinator	
d. Submit descriptions of all learning opportunities for inclusion in the CDC TEC, between July 1, 2014 and March 31, 2015.	Communications Coordinator	CDC TEC Staff
Objective 1: State-of-the-Science Information Development & Dissemination ***By March 31, 2015, the Center will create at least 20 state-of-the-science informational resources (e.g., PHIL Talks, toolkits, templates and protocols, blog posts, etc.) and disseminate them to health departments.***		
e. Post at least one template or protocol for health departments to download and customize on the online CBA portal, between August 1, 2014 and March 31, 2015.	Curriculum Development Specialist	
f. Assemble a behavioral assessment toolkit and post to the online CBA portal, by March 31, 2015.	Curriculum Development Specialist	
g. Produce at least three PHIL Talks and post to the online CBA portal, by March 31, 2015.	Communications Coordinator	Alan Zucker Enterprises
h. Write and publish monthly blog posts to the online CBA portal, between August 1, 2014 and March 31, 2015.	Communications Coordinator	
Objective 2: State-of-the-Science Training Development & Provision ***By March 31, 2015, the Center will develop and provide at least 10 state-of-the-science trainings (e.g., in-person trainings, webinars, eLearning modules, summits, boot camps) for health departments.***		
i. Host monthly webinars, between August 1, 2014 and March 31, 2015.	Communications Coordinator	
j. Develop at least one eLearning course, by February 28, 2014.	Curriculum Development Specialist	SweetRush, Monarch Media
k. Plan and host first "HIP Boot Camp" on PrEP/PEP implementation, by September 30, 2014	Program Deputy Director	Univ. Miami, UCSF, SF AIDS Foundation
l. Co-sponsor a reproductive health summit to highlight HIV prevention strategies for women and perinatal prevention, by November 30, 2014.	CBA Specialist	UCSF BAPAC & AETC
Objective 3: State-of-the-Science Technical Assistance ***By March 31, 2015, the Center will provide at least 40 episodes of brief (4 hours or less) TA, 15 episodes of in-depth (more than 4 hours long) TA, pilot two regional peer mentoring cohorts, and provide assistance with implementing mHealth and online tools to at least two health departments.***		

m.	Fulfill at least five requests per month for brief (four hours or less) technical assistance, between August 1, 2014 and March 31, 2015.	Program Manager, CBA Specialists, Faculty	
n.	Fulfill at least two requests per month for in-depth (more than four hours) technical assistance, between August 1, 2014 and March 31, 2015.	Program Manager, CBA Specialists, Faculty	
o.	Host at least three live chat "office hours" sessions per month featuring subject matter faculty, between August 1, 2014 and March 31, 2015.	Communications Coordinator, Faculty	
p.	Pilot regional peer-to-peer mentoring program with San Francisco Bay Area cohort, including a kick-off meeting to be held, by September 31, 2014.	CBA Specialist	Bay Area county health departments
q.	Launch a second regional peer-to-peer mentoring cohort with southeast US health departments, including a kick-off meeting to be held, by January 31, 2015.	CBA Specialist	University of Miami, Florida DPH, Houston DPH
r.	Hold at least six live chats for peer-to-peer mentoring cohorts, including three sessions for Bay Area cohort and three sessions for Southeast US cohort, by March 31, 2015.	CBA Specialist	
s.	Pilot the online, customizable HIV prevention, care, and treatment services resource guide platform with at least two health departments, by January 31, 2015.	Program Manager	RDE Systems

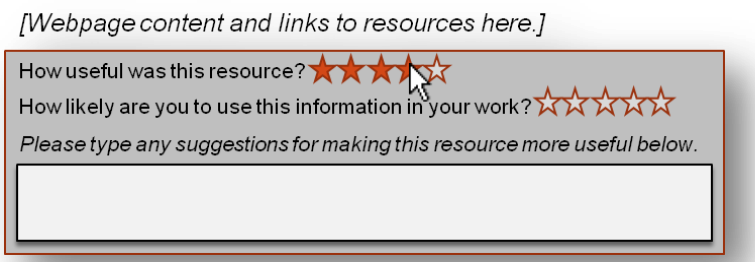
Phase III: Monitoring, Evaluation, and Compliance

The Monitoring, Evaluation, and Compliance phase is ongoing throughout the start-up and implementation phases. All CBA activities and products will be evaluated through satisfaction surveys and/or interviews that include questions on the recipient's overall impressions of the training or TA, faculty effectiveness, extent to which the recipient's objectives were met, and suggestions for improvement. This feedback will help refine and strengthen the Center's CBA offerings and ensure the Center provides high-quality, effective CBA services to health departments.

The Center will make every effort to ensure the highest possible response rates to its evaluation tools. The Center will ask health department partners to review draft instruments for clarity and usability, and will pilot surveys with a small subset of health departments. When feasible, we will embed survey tools into trainings, including administering surveys during in-person sessions and through the webinar interface. **We will also use a system of reminder emails and phone calls to promote high response rates** to surveys. This system includes sending an email that establishes a completion deadline; sending a reminder email just prior to this date; sending individual follow-up emails to those who do not respond by deadline; and making follow-up calls to any remaining individuals who have still not responded within a week of the deadline. Similarly, we will follow-up by email and phone with individuals that we plan to interview.

CBA Tracking: CBA Specialists and Faculty providing TA will enter their activities into CRIS in real-time. Similarly, the Curriculum Development Specialist will enter all training activities into CRIS. The Program Assistant will enter any activities and products that cannot be recorded in CRIS (e.g., blog posts, online chats) into the Center's internal CBA tracking system, a simple spreadsheet that records type of activity/products, date conducted/disseminated, faculty involved, topic area addressed, and health departments

served. Because health departments will be required to register to access the portal, portal logins, page views, and participation in forum discussions will be tracked automatically.



Evaluation of Information Development & Dissemination: The Evaluation Specialist will work with the AETC National Evaluation Center to draft and refine a survey to be included at the bottom of each page on the portal that contains an informational resource such as a blog post, tool kit, template, or PHIL Talk (see mock-up in the figure to the right). The Evaluation Specialist will also work with the evaluation center to develop a more in-depth, optional survey that will appear after a user responds to the initial questions about the resource. Once developed, the Evaluation Assistant will work with Monarch Media to embed these surveys on the portal. In addition, the Evaluation Specialist will select several individuals who have downloaded resources such as tool kits and templates and conduct informal interviews with these individuals to assess the usefulness of these materials. The Evaluation Specialist will generate monthly reports of user ratings and share this data, and a summary of findings from the informal interviews, at core CBA team meetings. The team will discuss this data and make recommendations for refining future offerings as needed.

Evaluation of Training: The Evaluation Specialist will work with the AETC National Evaluation Center to draft and refine a satisfaction survey template that can be used to evaluate trainings. This survey will be customized for each training to include learning objectives and ratings of self-efficacy to implement the specific HIP strategy covered in the training. For in-person trainings, the trainer will be responsible for providing participants with a copy of the survey. The eLearning course will contain a link to the survey on the last page. Toward the end of each webinar, the Communications Coordinator will pose evaluative questions on the screen that participants will respond to in real time. These anonymous responses will be recorded by the webinar software. After each training, the faculty who provided the training and the Center's core CBA team will review the training, the experience in the field, and evaluation findings to identify changes needed for CQI.

Evaluation of TA: The Program Manager will check-in monthly with each recipient of in-depth TA to assess the scope of work and their satisfaction with the faculty and the TA being provided. After completion of TA, recipients will be provided with satisfaction surveys to evaluate the faculty; the appropriateness of the TA to their needs; and the success of ongoing implementation and usefulness of the TA provided. The Evaluation Specialist will also conduct brief follow-up interviews at the conclusion of TA provision to identify key areas for improvement. The core CBA team and faculty providing TA will discuss all in-depth TA events and evaluation findings monthly to identify changes/follow-up needed for CQI.

Evaluation of Peer-to-Peer Mentoring: The Evaluation Specialist will collaborate with the AETC National Evaluation Center to develop interview guides to evaluate this program. The Evaluation Specialist will conduct key informant interviews with members of the Bay Area pilot cohort to evaluate overall satisfaction with the program successes, and challenges. The Evaluation Specialist will synthesize feedback gathered and use it to develop recommendations for implementing the program with future cohorts. The Evaluation Specialist will present these recommendations to the CBA Specialist leading the coordination of this program and to the core CBA team, who will work together to refine the plan for the second peer mentoring cohort. After the Southeast US cohort is launched, the Evaluation Specialist will also interview participants to ensure program changes were well received and investigate other potential areas for improvement.

Evaluation of Assistance With Implementing Online and mHealth Tools: In partnership with the AETC National Evaluation Center, the Evaluation Specialist will develop a key informant interview tool to evaluate the implementation of the online customizable HIV prevention, care, and treatment resource guide platform. This interview guide will include questions regarding the process of working with RDE Systems to customize this tool as well as the usability and usefulness of the tool itself. The Evaluation Specialist will conduct interviews with the health departments that participated in the pilot and will synthesize findings, develop recommendations for future rollout, and discuss these recommendations with the core CBA team. The team will modify processes for future implementation accordingly.

Compliance with all CDC Requirements: Throughout the project period, the Center will 1) implement the required general awardee activities to support effective, efficient, and culturally competent service delivery, and strengthen the capacity of the national HIV prevention workforce to optimize the planning, implementation, and sustainment of interventions and strategies for HIP within health departments; 2) participate in all data collection and reporting activities as required by CDC, including real-time data entry into CRIS and the submission of an annual report; and 3) attend the CBA Provider Institute.

The Curriculum Development Specialist will be responsible for submitting new materials for CDC review and taking the lead in any text changes. Faculty will review and make changes if needed. The Communications Coordinator will submit trainings and other events to CDC for inclusion in the Training Events Calendar (TEC). The Program Manager will take primary responsibility for compliance with all other CDC procedures, including use of CRIS, referring requests from CBOs or health care organizations to the Capacity Building Branch CRIS Coordinator, submitting Technical Review Responses, and preparing and submitting interim and annual progress reports. The Evaluation Specialist will also assist in the preparation of progress reports by providing appropriate data and drafting any sections relating to CBA recipient satisfaction. The Program Manager will also participate, and/or assign other staff to participate, in all post-award orientation, training, conference calls, and meetings of the CBA Provider Network. Additionally,

the Program Manager and other key staff will attend the two-day CBA Provider Institute. The Program Manager will also be responsible for planning an internal CBA program progress meeting to assess the Center's program, review evaluation findings, share any updates or changes in CDC protocols, identify successes and areas for improvement, and review progress toward completion of all outcomes and objectives. The Evaluation Specialist will support this event by summarizing and presenting feedback gathered to date.

The table below summarizes the outcome, objectives, and activities for Phase III: Monitoring, Evaluation, and Compliance.

Phase III Outcome: Evaluate all CBA activities for CQI and comply with all CDC requirements.		
Objective 1: CBA Tracking ***From August 1, 2014 through March 31, 2015, all training and TA services provided will be recorded in CRIS, all other services and products provided will be entered in internal tracking system, and online CBA portal usage data will be tracked through portal.***	**Primary SFDPH Staff Responsible**	**Collaborators and Partners**
a. All CBA faculty will be oriented to CRIS at the kickoff event, which will be held, by July 15, 2014.	Program Manager	
b. In real time, the Center's staff will enter all CBA activities into CRIS, between August 1, 2014 and March 31, 2015.	CBA Specialist, Faculty	
c. Enter all services and products not recorded by CRIS into internal tracking system, between August 1, 2014 and March 31, 2015.	Program Assistant	
d. Begin collecting portal usage data for all registered users, by August 1, 2014.	Program Assistant	Monarch Media
Objective 2: Evaluation of Information Development & Dissemination ***From August 1, 2014 through March 31, 2015, at least 70% of users accessing informational resources through the online CBA portal will provide feedback through a survey and/or interview.***		
e. Develop surveys for the online CBA portal, by July 15, 2014.	Evaluation Specialist	AETC National Evaluation Center
f. Embed surveys on online CBA portal, by July 31, 2014.	Evaluation Specialist	Monarch Media
g. For each tool uploaded (e.g., protocols, templates, toolkits), conduct at least 3 informal interviews with users that downloaded these tools, between August 1, 2014 and March 31, 2015.	Evaluation Specialist	
h. Generate monthly report of feedback on informational resources and discuss during team meetings, between August 1, 2014 and March 31, 2015.	Evaluation Specialist, core CBA team	
Objective 3: Evaluation of Training ***By March 31, 2015, at least 90% of in-person training participants and 70% of online training participants will complete a survey to assess satisfaction, cultural and linguistic appropriateness, and increases in skills, knowledge, and self-efficacy.***		
i. Develop a satisfaction survey to evaluate trainings by August 1, 2014.	Evaluation Specialist	AETC, National Evaluation Center
j. Provide all participants with a survey to complete after every training, between August 1, 2014 and March 31, 2015.	Varies by training type	
k. Debrief with training faculty after every training, between August 1, 2014 and March 31, 2015.	Core CBA team, faculty	
Objective 4: Evaluation of Brief TA ***By March 31, 2015, at least 80% of recipients of brief TA will complete a satisfaction survey.***		

l. Develop a TA satisfaction survey template to evaluate brief TA episodes, by July 15, 2014.	Evaluation Specialist	AETC National Evaluation Center
m. Provide recipients with a TA survey to complete after each provision of brief TA, between August 1, 2014 and March 31, 2015.	Evaluation Specialist	
n. Debrief with TA faculty after each provision of brief TA, between August 1, 2014 and March 31, 2015.	Core CBA team, faculty	
Objective 5: Evaluation of In-Depth TA ***By March 31, 2015, at least 90% of recipients of in-depth TA will provide feedback through the survey or interview, or through informal check-ins.***		
o. Develop key informant interview guide and survey template to evaluate in-depth TA, by July 15, 2014.	Evaluation Specialist	AETC National Evaluation Center
p. Conduct informal check-in each month during in-depth TA, between August 1, 2014 and March 31, 2015.	Program Manager	
q. Provide satisfaction survey after in-depth TA is complete, between August 1, 2014 and March 31, 2015.	Evaluation Specialist	
r. Conduct follow-up interviews with recipients after TA is complete, between August 1, 2014 and March 31, 2015.	Evaluation Specialist	
s. Discuss all in-depth TA events and evaluation findings on a monthly basis to identify changes/follow-up needed for CQI, between August 1, 2014 and March 31, 2015.	Core CBA team, faculty	
Objective 6: Evaluation of Peer-to-Peer Mentoring ***By March 31, 2015, conduct interviews with at least 10 participants in the peer-to-peer regional mentoring programs and use findings for CQI.***		
t. Develop and implement a key informant interview guide with staff from at least 5 health departments participating in the Bay Area mentoring program, by November 15, 2014.	Evaluation Specialist	AETC National Evaluation Center
u. Synthesize findings, develop recommendations, and change plans accordingly for future cohorts, by December 15, 2014.	Evaluation Specialist, CBA Specialist, Core CBA team	
v. Conduct key informant interviews with staff from at least 5 health departments participating in the Southeast US mentoring program, by March 15, 2015.	Evaluation Specialist	
Objective 7: Evaluation of Assistance With Implementing Online and mHealth Tools ***By March 31, 2015, gather feedback from all health departments participating in the pilot of the online HIV resource guide platform and use data for CQI.***		
w. Develop and implement a key informant interview guide with all health departments participating in the pilot, by March 15, 2015.	Evaluation Specialist	AETC National Evaluation Center
x. Synthesize findings, and develop and implement recommendations for future roll out, by March 31, 2015.	Evaluation Specialist, CBA Specialist, core CBA team	
Objective 8: Compliance with All CDC Requirements ***Throughout the project period, the Center will comply with all CDC requirements.***		
y. Submit new materials for CDC review process on a monthly basis, between August 1, 2014 and March 31, 2015.	Curriculum Development Specialist	
z. Respond to CBA requests consistent with CDC procedures, including use of CRIS and list all training events to the TEC, between August 1, 2014 and March 31, 2015.	Program Manager, Communications Coordinator	
aa. Refer all CBA requests from CBOs or health care organizations to the Capacity Building Branch CRIS Coordinator, between August 1, 2014 and March 31, 2015.	Program Manager	
bb. Hold internal CBA program progress meeting, by October 15, 2014.	Program Manager, core CBA	

	staff and faculty	
cc. Send core CBA staff to the two-day CBA Provider Institute, by September 30, 2014 (or the dates chosen by CDC).	Program Manager, CBA Specialists, lead faculty	
dd. Submit year 1 interim progress report and year 2 budget to CDC, by October 30, 2014 (or the date chosen by CDC).	Program Manager, Evaluation Specialist	
ee. Submit all Technical Review Responses to CDC by designated deadlines, between August 1, 2014 and March 31, 2015.	Program Manager	
ff. Begin preparing the annual progress report for submission to CDC in the beginning of year 2 (will submit by due date CDC provides in year 2), by March 31, 2015.	Program Manager, Evaluation Specialist	
gg. Participate in post-award orientation, training, conference calls, and meetings of the CBA Provider Network, between April 1, 2014 and March 31, 2015.	Program Manager, core CBA team, faculty (as appropriate)	

In summary, by the end of Year 1, the Center expects progress toward achieving the overall five-year CBA program objectives. The table below compares the five-year objectives with the anticipated progress toward those objectives by the end of Year 1. For example, by the end of Year 1, we anticipate that at least one staff person from **75%** of health departments will register for the portal and report increased knowledge about our services. Through on-going efforts we anticipate boosting this number to **90%** by the end of Year 5.

One-Year Performance Measure	**Five-Year Performance Measure**	**Data Source**
At least one staff member from at least **75%** of HDs will register through the online CBA portal and will report increased knowledge about the Center's CBA services.	**90%**	Online CBA portal analytics
At least **60%** of online CBA portal users will access the Center's training and/or one-to-one TA.	**70%**	CRIS data
At least **70%** of CBA recipients will report high satisfaction with the Center's CBA services.	**80%**	Satisfaction surveys
At least **75%** of CBA recipients will report increases in knowledge, skills, and self-efficacy after receiving the Center's CBA services as compared to baseline.	**90%**	Satisfaction surveys
At least **70%** of recipients will report an increase in intent to use acquired knowledge and skills.	**70%**	Satisfaction surveys

Summary timeline for key Year 1 activities

Activities	Apr '14	May '14	June '14	July '14	Aug '14	Sept '14	Oct '14	Nov '14	Dec '14	Jan '15	Feb '15	Mar '15
Start-Up												
Hire & assemble team	X	X										
Develop online CBA Portal	X	X	X	X								
Conduct formal assessment & assemble report on findings	X	X	X	X								
Hold Orientation and Training Event with CBA team				X								
Implementation												
Marketing & Outreach												
Develop and disseminate introductory marketing materials					X							
Develop and disseminate semiannual newsletters							X					X
Information Dissemination												
Post templates/protocols				X	X	X	X	X	X	X	X	X
Assemble behavioral assessment toolkit												X
Post and create PHIL Talks						X			X			X
Publish monthly blog posts					X	X	X	X	X	X	X	X
Training												
Host webinars					X	X	X	X	X	X	X	X
Develop eLearning course											X	
Organize PEP/PrEP boot camp						X						
Co-sponsor reproductive health summit*								X				
Technical Assistance												
Fulfill pull TA requests					X	X	X	X	X	X	X	X
Host live chat "office hours" featuring faculty					X	X	X	X	X	X	X	X
Organize peer-to-peer mentoring meetings						X				X		
Pilot online HIV services resource guide platform										X		
Monitoring & Evaluation												
Develop CBA evaluation tools			X	X								
Track CBA provision in CRIS and internal system					X	X	X	X	X	X	X	X
Collect & assess feedback on CBA services					X	X	X	X	X	X	X	X
Participate in all required post-award activities (orientation, trainings, conference calls, meetings)	X	X	X	X	X	X	X	X	X	X	X	X
Attend 2-day CBA Provider Institute**						X**						
Hold CBA team progress meeting							X					
Prepare interim & annual progress reports							X					X
Comply with all other CDC requirements	X	X	X	X	X	X	X	X	X	X	X	X

* Will time meeting to coincide with CDC prevention conference

**Estimate of when meeting will take place. We will attend based on CDC announcement of Institute dates.

iii. References for Narrative and Work Plan

See reference box on the following page.

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