OMB Number: 4040-0004
Expiration Date: 10/31/2019

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

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

* b. Employer/Taxpayer Identification Number (EIN/TIN): 94-6000417

* c. Organizational DUNS: 1037173360000

d. Address:

* Street1: 25 Van Ness Ave, suite 500
Street2:
* City: San Francisco
County/Parish:
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 94102-6056

e. Organizational Unit:

Department Name:

Division Name:

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

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

Title: Director of Community Health Equity & Promoti

Organizational Affiliation:

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

* Email: tracey.packer@sfdph.org

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

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

Centers for Disease Control - NCHHSTP

11. Catalog of Federal Domestic Assistance Number:

93.940

CFDA Title:

HIV Prevention Activities_Health Department Based

*** 12. Funding Opportunity Number:**

CDC-RFA-PS18-1802

* Title:

Integrated HIV Surveillance and Prevention Programs for Health Departments

13. Competition Identification Number:

CDC-RFA-PS18-1802

Title:

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

Add Attachment | Delete Attachment | View Attachment

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

San Francisco Dept of Public Health High Impact Prevention

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: CA-12 * b. Program/Project: Ca-12

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 01/01/2018 * b. End Date: 12/31/2018

18. Estimated Funding ($):

* a. Federal	7,257,408.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	7,257,408.00

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

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

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

☐ c. Program is not covered by E.O. 12372.

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

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

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

☒ ** I AGREE

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

Authorized Representative:

Prefix:	
* First Name:	Tomas
Middle Name:	
* Last Name:	Aragon
Suffix:	
* Title:	Director of Population Health Division
* Telephone Number:	415-554-2898
Fax Number:	415-554-2710
* Email:	Tomas.aragon@sfdph.org
* Signature of Authorized Representative:	Completed by Grants.gov upon submission.
* Date Signed:	Completed by Grants.gov upon submission.

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

Project Abstract Summary

Program Announcement (CFDA)

93.940

Program Announcement (Funding Opportunity Number)

CDC-RFA-PS18-1802

Closing Date

09/13/2017

Applicant Name

San Francisco Dept of Public Health

Length of Proposed Project

5

Application Control No.

Federal Share Requested (for each year)

Federal Share 1st Year	Federal Share 2nd Year	Federal Share 3rd Year
$ 7,257,408	$ 7,257,408	$ 7,257,408
Federal Share 4th Year	**Federal Share 5th Year**	
$ 7,257,408	$ 7,257,408	

Non-Federal Share Requested (for each year)

Non-Federal Share 1st Year	Non-Federal Share 2nd Year	Non-Federal Share 3rd Year
$ 0	$ 0	$ 0
Non-Federal Share 4th Year	**Non-Federal Share 5th Year**	
$ 0	$ 0	

Project Title

San Francisco Dept of Public Health High Impact Prevention

Project Abstract Summary

Project Summary

In 2013 SF launched the "Getting to Zero SF" initiative with the goals of zero new HIV infections, zero HIV-related deaths, and zero HIV-related stigma and discrimination. SF has made substantial progress toward these goals and has improved each step along the HIV care continuum; however, surveillance data show that significant disparities in linkage, retention, and viral suppression among people living with HIV remain. African-Americans and Latinos, trans and cis-gender women, people who inject drugs, and people experiencing homelessness are less likely to be virally suppressed. In terms of new diagnoses, people of color make up an increasingly higher percentage of new diagnoses. SFDPH's Component A proposal expands on the Department of Public Health's (SFDPH's) commitment to fully integrate surveillance and prevention programs. It supports strategies that have contributed to the dramatically decreasing HIV incidence in recent years, and implements shifts needed to align with the current epidemiology, including a much stronger equity focus. SFDPH's Component B proposal describes Project OPT-IN ("Opt-in" to Outreach, Prevention and Treatment) - an innovative, broadly collaborative project serving those whose lives are deeply affected by the social determinants of health, such as people experiencing homelessness. We must do a better job with these groups if we hope to "get to zero," for all SF populations.

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

75000

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
4040-0013

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

4. Name and Address of Reporting Entity:

☒ Prime ☐ SubAwardee

*Name: San Francisco Department of Public Health

*Street 1: 25 Van Ness Ave, 5ht Fl Street 2:

*City: San Francisco State: CA: California Zip: 94102

Congressional District, if known: CA-12

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

Centers for Disease Control and Preventi

7. * Federal Program Name/Description:

HIV Prevention Activities_Health Department Based

CFDA Number, *if applicable:* 93.940

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: *First Name: N/A Middle Name:

*Last Name: N/A Suffix:

*Street 1: Street 2:

*City: State: Zip:

b. Individual Performing Services (including address if different from No. 10a)

Prefix: *First Name: N/A Middle Name:

*Last Name: N/A Suffix:

*Street 1: Street 2:

*City: State: Zip:

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** Prefix: *First Name: Tomas Middle Name:

*Last Name: Aragon Suffix:

Title: **Telephone No.:** **Date:** Completed on submission to Grants.gov

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Standard Form - LLL (Rev. 7-97)

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 01/31/2019

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Component A- HIV Prevention Budget	93.940	$	$	$ 4,409,245.00	$	$ 4,409,245.00
2. Component A - HIV Surveillance Budget	93.940			848,163.00		848,163.00
3. Component B Budget	93.940			2,000,000.00		2,000,000.00
4.						
5. Totals		$	$	$ 7,257,408.00	$	$ 7,257,408.00

Standard Form 424A (Rev. 7- 97)
Prescribed by OMB (Circular A -102) Page 1

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) Component A- HIV Prevention Budget	(2) Component A - HIV Surveillance Budget	(3) Component B Budget	(4)	Total (5)
a. Personnel	$ 1,130,119.00	$ 413,236.00	$ 415,364.00	$	$ 1,958,719.00
b. Fringe Benefits	474,650.00	165,295.00	174,453.00		814,398.00
c. Travel	7,784.00	13,216.00	8,844.00		29,844.00
d. Equipment	0.00	0.00	0.00		0.00
e. Supplies	22,325.00	6,443.00	19,033.00		47,801.00
f. Contractual	2,448,837.00	117,401.00	1,232,778.00		3,799,016.00
g. Construction	0.00	0.00	0.00		0.00
h. Other	43,000.00	29,271.00	45,687.00		117,958.00
i. Total Direct Charges (sum of 6a-6h)	4,126,715.00	744,862.00	1,896,159.00		$ 6,767,736.00
j. Indirect Charges	282,530.00	103,301.00	103,841.00		$ 489,672.00
k. TOTALS (sum of 6i and 6j)	$ 4,409,245.00	$ 848,163.00	$ 2,000,000.00	$	$ 7,257,408.00
7. Program Income	$	$	$	$	$

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Prescribed by OMB (Circular A -102) Page 1A

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Component A- HIV Provention Budget	$ 0.00	$ 0.00	$ 0.00	$ 0.00
9. Component A - HIV Surveillance Budget	0.00	0.00	0.00	0.00
10. Component B Budget	0.00	0.00	0.00	0.00
11.				
12. TOTAL (sum of lines 8-11)	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 7,257,408.00	$ 1,814,352.00	$ 1,814,352.00	$ 1,814,352.00	$ 1,814,352.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 7,257,408.00	$ 1,814,352.00	$ 1,814,352.00	$ 1,814,352.00	$ 1,814,352.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Component A- HIV Prevention Budget	$ 4,409,245.00	$ 4,409,245.00	$ 4,409,245.00	$ 4,409,245.00
17. Component A - HIV Surveillance Budget	848,163.00	848,163.00	848,163.00	848,163.00
18. Component B Budget	2,000,000.00	2,000,000.00	2,000,000.00	2,000,000.00
19.				
20. TOTAL (sum of lines 16 - 19)	$ 7,257,408.00	$ 7,257,408.00	$ 7,257,408.00	$ 7,257,408.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: 6,767,736

22. Indirect Charges: 489,672

23. Remarks: indirect costs are 25% of total salaries

CHECKLIST

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete each page of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last pages of the signed original of the application.

Type of Application: ☒ New ☐ Noncompeting Continuation ☐ Competing Continuation ☐ Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.	Included	NOT Applicable
1. Proper Signature and Date on the SF 424 (FACE PAGE)	☒	
2. If your organization currently has on file with HHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS 690)		
☐ Civil Rights Assurance (45 CFR 80)		
☐ Assurance Concerning the Handicapped (45 CFR 84)		
☐ Assurance Concerning Sex Discrimination (45 CFR 86)		
☐ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)		
3. Human Subjects Certification, when applicable (45 CFR 46)	☐	☒

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☐	☒
2. Has the appropriate box been checked on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	☒	
3. Has the entire proposed project period been identified on the SF-424 (FACE PAGE)?	☒	
4. Have biographical sketch(es) with job description(s) been provided, when required?	☒	☐
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	☒	
6. Has the 12 month narrative budget justification been provided?	☒	☐
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☐	☒
8. For a Supplemental application, does the narrative budget justification address only the additional funds requested?	☐	☒
9. For Competing Continuation and Supplemental applications, has a progress report been included?	☐	☒

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made

Prefix: | First Name: Christine | Middle Name:
Last Name: Siador | Suffix:
Title: Deputy Director, Population Health Division
Organization: Department of Public Health
Street1: 25 Van Ness, Suite 200
Street2:
City: San Francisco
State: CA: California | ZIP / Postal Code: 94102 | ZIP / Postal Code4:
E-mail Address: christine.siador@sfdph.org
Telephone Number: 628-206-7621 | Fax Number:

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

Prefix: | First Name: Tracey | Middle Name:
Last Name: Packer | Suffix:
Title: Director of CHEP
Organization: San Francisco Dept of Public Health
Street1: 25 Van Ness Ave, 6th FL
Street2:
City: San Francisoc
State: CA: California | ZIP / Postal Code: 94102 | ZIP / Postal Code4:
E-mail Address: tracey.packer@sfdph.org
Telephone Number: 415-4376-223 | Fax Number:

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

☐ (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.

☐ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.

☐ (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.

☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.

☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of HHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: *(Agency)* on *(Date)*

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in the Federal Register on June 24, 1983, along with a notice identifying the Department's programs that are subject to the provisions of Executive Order 12372. Information regarding HHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.

BY SIGNING THE FACE PAGE OF THIS APPLICATION, THE APPLICANT ORGANIZATION CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE, COMPLETE, AND ACCURATE TO THE BEST OF THE SIGNER'S KNOWLEDGE, AND THE ORGANIZATION ACCEPTS THE OBLIGATION TO COMPLY WITH U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES' TERMS AND CONDITIONS IF AN AWARD IS MADE AS A RESULT OF THE APPLICATION. THE SIGNER IS ALSO AWARE THAT ANY FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS OR CLAIMS MAY SUBJECT THE SIGNER TO CRIMINAL, CIVIL, OR ADMINISTRATIVE PENALTIES.

THE FOLLOWING ASSURANCES/CERTIFICATIONS ARE MADE AND VERIFIED BY THE SIGNATURE OF THE OFFICIAL SIGNING FOR THE APPLICANT ORGANIZATION ON THE FACE PAGE OF THE APPLICATION:

Civil Rights – Title VI of the Civil Rights Act of 1964 (P.L. 88-352), as amended, and all the requirements imposed by or pursuant to the HHS regulation (45 CFR part 80).

Handicapped Individuals – Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 84).

Sex Discrimination – Title IX of the Educational Amendments of 1972 (P.L. 92-318), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 86).

Age Discrimination – The Age Discrimination Act of 1975 (P.L. 94-135), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 91).

Debarment and Suspension – Title 2 CFR part 376.

Certification Regarding Drug-Free Workplace Requirements – Title 45 CFR part 82.

Certification Regarding Lobbying – Title 32, United States Code, Section 1352 and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 93).

Environmental Tobacco Smoke – Public Law 103-227.

Program Fraud Civil Remedies Act (PFCRA)

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** Narrative A and B v3 MASTER.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** Component A - HIV Prevention Budget Narrative.pdf

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

Other Attachment File(s)

*** Mandatory Other Attachment Filename:** Cover Letter FINAL.pdf

Add Mandatory Other Attachment | Delete Mandatory Other Attachment | View Mandatory Other Attachment

To add more "Other Attachment" attachments, please use the attachment buttons below.

Add Optional Other Attachment | Delete Optional Other Attachment | View Optional Other Attachment

City and County of San Francisco
Mayor Edwin Lee

Department of Public Health
Barbara A. Garcia, MPA
Director of Health

September 11, 2017

Renata Ellington, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS D-21
Atlanta, GA 30333

RE: Integrated HIV Surveillance and Prevention Programs for Health Departments
CDC-RFA-PS18-1802

Dear Ms.Ellington,

The San Francisco Department of Public Health (SFDPH), Population Health Division (PHD), is pleased to present its grant application for Component A and Component B of PS-18-1802, "Integrated HIV Surveillance and Prevention Programs for Health Departments".

San Francisco currently implements all eleven strategies and activities as described in Component A of the funding announcement and funds from this cooperative agreement will continue to support all of these with the exception of Strategy Six, "Conduct Perinatal HIV Prevention and Surveillance Activities" which is well-supported with other resources. We will continue to report on all activities.

We are particularly pleased to apply for Component B, the Demonstration Project. San Francisco has had many successes in fighting HIV, decreasing new HIV infections, reducing time from diagnosis to treatment, and increasing the percentages of HIV positive persons in care, on treatment and virally suppressed. This success has not been shared equally across all populations and clients experiencing the poorest outcomes are the most difficult to reach, have competing and complex needs such as homelessness and substance use issues. San Francisco's new project, "OPT-IN" (Outreach, Prevention, Treatment, Into) creates a system of prevention and care to reach these persons through field-delivered services at encampments, street-based medicine, and street-based navigation.

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

Sincerely,

Tomás J. Aragón, MD, DrPH
Health Officer, City & County of San Francisco
Director, Population Health Division (PHD)

Christine Siador, MPH
Deputy Director, Population Health Division
Director, Operations, Finance & Grants Management Branch

25 Van Ness Avenue, Suite 500, San Francisco, CA 94102
Phone (415) 437-6200 Fax (415) 431-7154

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

Table of Contents

COMPONENT A NARRATIVE

A. BACKGROUND

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

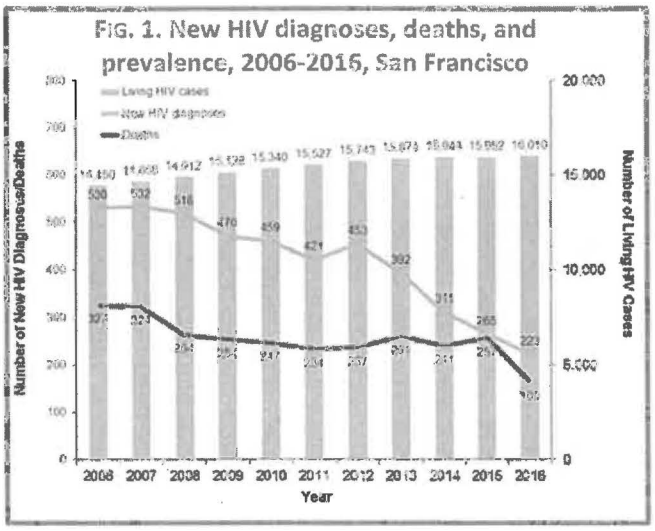


FIG. 1. New HIV diagnoses, deaths, and prevalence, 2006-2016, San Francisco

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

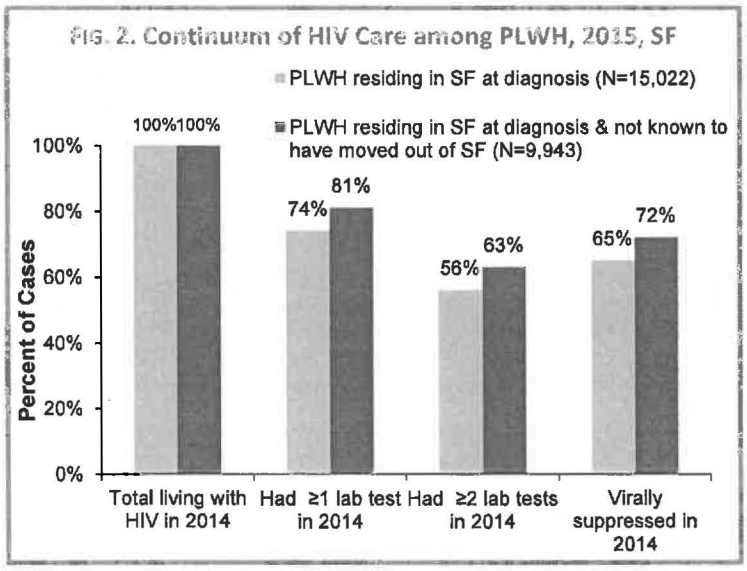
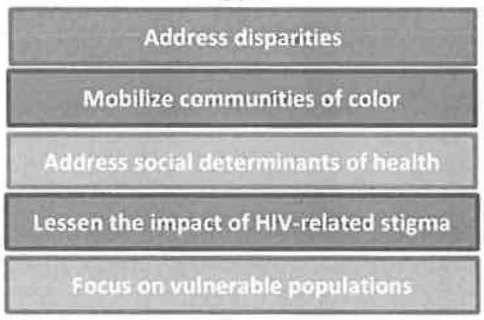


FIG. 2. Continuum of HIV Care among PLWH, 2015, SF

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

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

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



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

B. APPROACH

i. Purpose

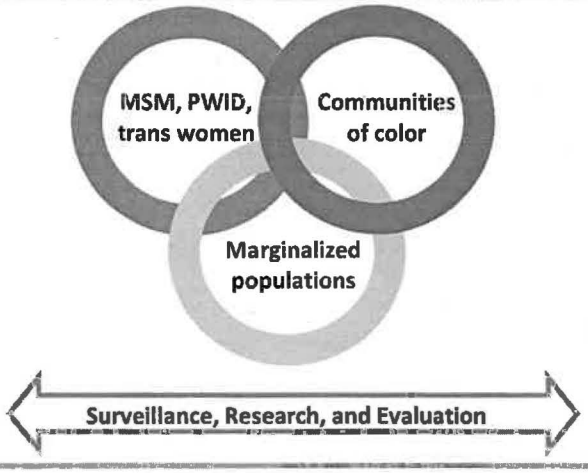
SF's integrated prevention and surveillance program (FIG. 4) will maintain its strong emphasis on HIP for high prevalence populations (MSM, PWID, trans women), while bringing an increased focus to the prevention needs in communities of color and the HIV-related disparities they experience in new infections,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

FIG. 4. Current and Proposed Focus

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

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

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



ii. Outcomes

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

FIG. 5. Project Period Outcomes

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

iii. Strategies and Activities

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

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

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

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

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

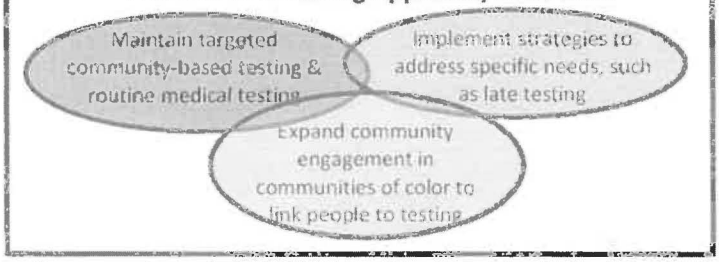
SFDPH will also conduct **HIV prevention program monitoring and evaluation**. Community-based organizations providing HIV testing will enter test-level data into EvaluationWeb by the end of the week following the week in which to test was conducted; test data from medical settings and select community-based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

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

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

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

FIG. 6. SFDPH Testing Approach, 2018-2022



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

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

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

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

1) SFDPH will maintain:

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

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

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

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

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

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

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

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

Strategy 3: Maintain HIV transmission cluster/outbreak response plan

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

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

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

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

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

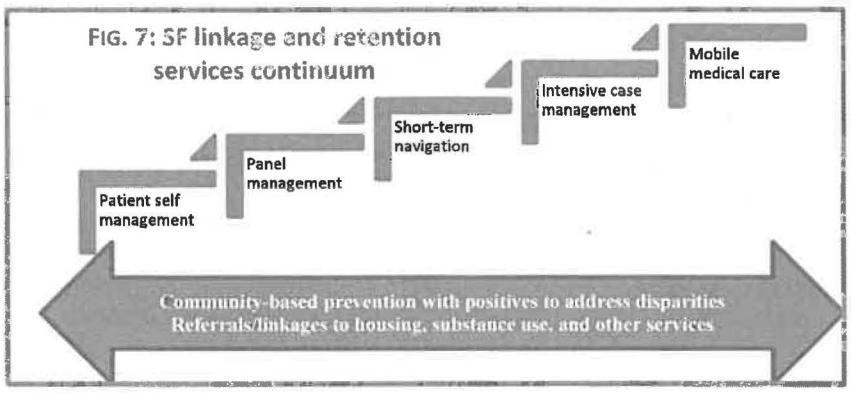


FIG. 7: SF linkage and retention services continuum

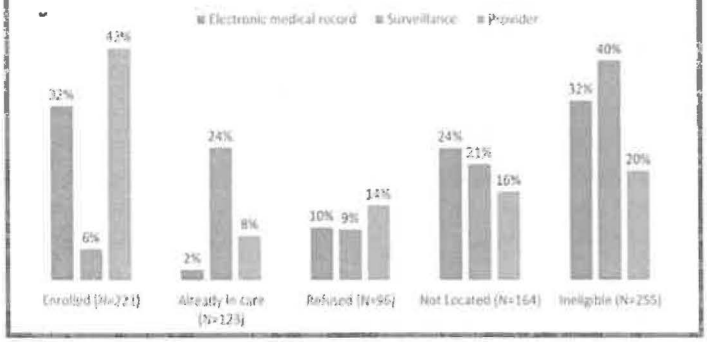
Our integrated HIV prevention and surveillance program, using core surveillance and other data as well as community input, will design and implement specific community-based, clinical, and DTC strategies to improve retention. For retention, as for linkage, our key team is LINCS. In 2015-2017, among patients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

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

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

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

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



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

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

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

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

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

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

FIG. 9: SFDPH PrEP Strategy

PrEP in Clinical Settings

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

PrEP in Community-Based Settings

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

Community-Level PrEP Intervention

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

Provider & Systems Capacity-Building

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

Pilot Projects

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

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

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

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

Strategy 6: Conduct perinatal HIV prevention and surveillance activities

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

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

Strategy 7: Conduct community-level HIV prevention activities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

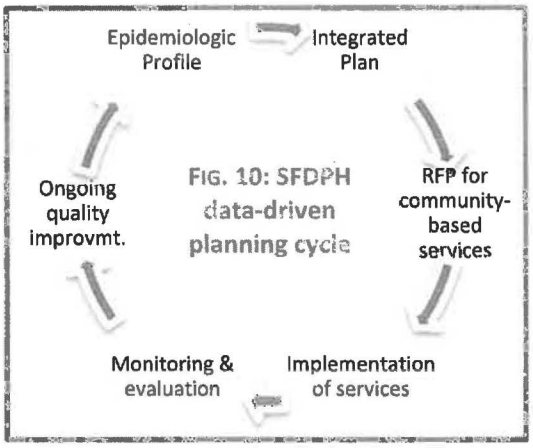


FIG. 10: SFDPH data-driven planning cycle

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

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

Collaborations

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

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

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

Target Populations and Health Disparities

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

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

D. ORGANIZATIONAL CAPACITY OF APPLICANTS TO IMPLEMENT THE APPROACH

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

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

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

i. Workforce Capacity

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

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

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

E. WORK PLAN – See Attachment.

COMPONENT B DEMONSTRATION PROJECT NARRATIVE

A. BACKGROUND

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

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

B. APPROACH

i. Purpose and Rationale

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

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

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

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

i. Outcomes

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

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

ii. Strategies and Activities

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

FIG. 1: *Project OPT-IN*

Warm Handoffs

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

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

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

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

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

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

Yellow Zone Efforts – Community-Based Intensive Case Management

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

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

Green Zone Efforts – Clinic-Based Care Coordination

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

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

Systems Transformation

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

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

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

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

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

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

D. ORGANIZATIONAL CAPACITY OF SFDPH TO IMPLEMENT THE APPROACH

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

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

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

E. WORK PLAN – See Attachments.

COMPONENT A WORK PLAN

A. FIVE-YEAR PROJECT OVERVIEW

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

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

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

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

Strategy 3: Maintain HIV transmission cluster/outbreak response plan

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

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

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

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

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

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

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

Strategy 6: Conduct perinatal HIV prevention and surveillance activities

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

Strategy 7: Conduct community-level HIV prevention activities

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

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

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

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

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

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

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

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

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

B. 2018 Work Plan

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

CDC Outcome 1.1: Improved monitoring of trends in HIV infections

SFDPH Year 1 SMART Objectives

1.1.1. By September 30, 2018, publish the 2017 HIV Epidemiology Annual report, which will include 5 years of trends for new HIV diagnoses, deaths and people living with HIV and 4 years of trends for HIV indicators along the HIV care continuum (linkage to care, retention in care and viral suppression).

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
1.1.a. Analyze surveillance data and prepare the 2017 HIV Epidemiology Annual Report.	See EPMP Measure 1.1.1a	Ling Hsu Susan Scheer	Sep
1.1.b. Publish and disseminate a comprehensive Integrated HIV Epidemiologic Profile, for inclusion in the SF EMA Integrated Plan.	See EPMP Measure 1.1.1b	Ling Hsu Susan Scheer Tracey Packer	Dec
1.1.c. Disseminate annual HIV surveillance reports to stakeholders, including posting on website and presenting data trends to HCPC.	See EPMP Local Measure 1.A.1	Susan Scheer Tracey Packer	Dec

CDC Outcome 1.2: Improved completeness, timeliness, and quality of HIV surveillance and prevention program data

SFDPH Year 1 SMART Objectives

1.2.1. By December 31, 2018 meet standards detailed for case ascertainment, death ascertainment, risk factor reporting, duplicate review, geocoding, laboratory reporting, timeliness, data quality, completeness, and dissemination as detailed in the *Technical Guidance for HIV Surveillance Programs.*

1.2.2. By December 31, 2018 meet all standards detailed in the *National HIV Prevention Program Monitoring and Evaluation Guidance* for key NHM&E program performance variables, timeliness, data quality, completeness, and dissemination, assessed as required by CDC standards.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
HIV Surveillance Data			
1.2.a. Conduct case ascertainment to identify and report all persons with diagnosed HIV infection using active and passive surveillance methods.	See EPMP Measures 1.2.2 – 1.2.3	Ling Hsu	ongoing

1.2.b. Conduct death ascertainment, including matches with local death certificate data, National Death index and SSDMF, and review of medical records to obtain information on detailed causes of and risk factors for death.	See EPMP Measures 1.2.1a – 1.2.1d	Ling Hsu	Dec
1.2.c. Conduct risk factor ascertainment for all cases of HIV infection, including prevalent cases.	See EPMP Measure 1.2.5	Ling Hsu	ongoing
1.2.d. Conduct monthly intrastate de-duplication of HIV cases and twice a year routine interstate duplicate review (RIDR).	See EPMP Measures 1.2.6 – 1.2.7	Ling Hsu	ongoing
1.2.e. Work with laboratories and State Office of AIDS to collect, report to CDC, and ensure complete laboratory reporting of all HIV-related laboratory results including all CD4 and viral load test results, all tests from the diagnostic algorithm, and HIV sequence results.	See EPMP Measures 1.2.8 – 1.2.11 and 2.B.1 – 2.B.2	Ling Hsu	ongoing
1.2.f. Collect and enter into eHARS antiretroviral therapy (ART) use history data	See EPMP Measure 1.2.12	Ling Hsu	ongoing
1.2.g. Identify early HIV infection using laboratory tests, testing history or clinical evidence suggestive of acute infection and expand collection of documented negative HIV test results.	See EPMP Measures 1.2.13a – 1.2.13b, and Local Measure 1.2.13c	Ling Hsu	ongoing
1.2.h. Perform quality assurance on data that are required by CDC or critical for reporting and analysis and conduct annual evaluation of HIV surveillance system.	See EPMP Measure 1.2.4	Ling Hsu	ongoing
1.2.i. Conduct prospective medical chart reviews to document vital status, use of additional therapeutic and prophylactic treatments, subsequent opportunistic illnesses, most recent address, and additional CD4 and viral load results on living HIV/AIDS cases that did not receive a chart review within the last 12 months.	At least 2,000 medical chart reviews completed	Ling Hsu	Dec

1.2.j. Investigate cases of public health importance (COPHI) within one month of notification of case.	Documentation of NIR case investigation; notification of State Office of AIDS and CDC of COPHI cases identified and reclassified	Ling Hsu	ongoing
1.2.k. Analyze HIV surveillance data to monitor HIV drug resistance and HIV genetic diversity.	Analyses completed and findings included in the 2017 HIV Epidemiology Annual Report	Mia Chen	Sep
1.2.l. Report surveillance data to CDC in required format by required deadlines.	All case information entered using California centralized eHARS	Ling Hsu	ongoing
1.2.m. Incorporate the use of analytic pipelines and data processing tools, by using CDC-developed SAS programs and methods to estimate HIV incidence and prevalence including undiagnosed HIV infection.	Complete estimates of HIV incidence and prevalence	Ling Hsu	Dec
1.2.n. Collaborate with CDC funded programs such as the Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement regarding electronic case reporting and electronic laboratory reporting initiatives.	Reporting of HIV sequence data from one laboratory with technical difficulty, as the result of technical assistance provided by CDC and APHL	Mia Chen	Dec
HIV Prevention Program Data			
1.2.o. Collect and enter all 18-1802-funded test events into EvaluationWeb and ensure data quality and completeness.	See EPMP Measures 1.2.14-1.2.15	Thomas Knoble	ongoing

1.2.p. Verify all HIV-positive tests as known or new using HIV surveillance.	See EPMP Measure 1.2.16	Ling Hsu	ongoing
1.2.q. Report program data to CDC in required format by required deadlines.	On time and accurate data submissions	John Melichar	as required

CDC Outcome 1.3: Increased ability to describe the geographic distribution of HIV and understand the social determinants of health in relation to HIV and HIV-related health disparities

SFDPH Year 1 SMART Objectives

1.3.1. By December 31, 2018, create and disseminate maps that display patterns between HIV morbidity and social determinants of health.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
1.3.a. Obtain a Memorandum of Agreement (MOA) for the 5-year funding period to submit geocoded data to CDC.	See EPMP Measure 1.3.1	Ling Hsu	Dec
1.3.b. Ascertain complete address at time of HIV diagnosis and update the most recent address through laboratory reporting, follow-up review of medical records, LINCS databases, and other databases.	See EPMP Local Measure 1.3.4	Ling Hsu	ongoing
1.3.c. Apply geocoding standards provided by CDC, perform data cleaning and standardization and geocode, to the census tract level, residence at HIV diagnosis as well as most current residence.	See EPMP Measures 1.3.2 – 1.3.3	Ling Hsu	ongoing

CDC Strategy 2: Identify persons with HIV and uninfected persons at risk for HIV
(Note: D2C activities are listed under CDC Strategy 4.)

CDC Outcome 2.1: Increased number of persons who are aware of their HIV status
SFDPH Year 1 SMART Objectives*

2.1.1. By December 31, 2018, HIV prevention community-based organizations and SFDPH City Clinic will maintain their annual HIV testing numbers at 27,000 tests, as measured by EvaluationWeb.

2.1.2. By December 31, 2018, HIV prevention community-based organizations and SFDPH City Clinic will maintain the percentage of tests among persons at risk for HIV infection at 77% as measured by EvaluationWeb data.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
2.1.a. Continue high volume community-based testing for high prevalence populations (MSM, trans women, PWID) at San Francisco AIDS Foundation's Magnet clinic, UCSF Alliance Health Project, and SFDPH City Clinic.	See EPMP Measures 2.A.1 – 2.A.3, 2.C.1, and 2.1.1-2.1.5	Thomas Knoble Stephanie Cohen	ongoing
2.1.b. Collaborate with HIV community-based organizations (CBOs) and the HCPC to develop a plan for shifting the community-based testing strategy to align with the current epidemiology (see narrative)	At least 3 input/planning meetings with CBOs; at least 1 discussion with HCPC	Jose Luis Guzman	Jun
2.1.c. Provide capacity-building assistance to HIV prevention CBOs to align programs with current epidemiology.	Documentation of CBA provided	CHEP Program Liaisons; LINCS staff	ongoing
2.1.d. Issue community-based HIV prevention RFP, which will include community-based testing services	RFP publication	Tracey Packer	Sep
2.1.e. Conduct public health detailing to increase HIV testing in EDs, urgent care, and primary care	Documentation of detailing visits	Darpun Sachdev	Sep
2.1.f. Continue high-yield partner services activities for new positives (also contributes to Outcome 2.2) using data from HIV surveillance to identify all new positives including those diagnosed in private medical settings	See EPMP Measures 2.D.1 – 2.D.4	LINCS staff Mia Chen	ongoing

2.1.g. Develop plan to expand partner services to not-in-care LINCS navigation clients (also contributes to Outcome 2.2)	Completed plan	Darpun Sachdev	Jun

*Inclusive of all testing regardless of funding source.

CDC Outcome 2.2: Increased participation in HIV partner services among persons with diagnosed HIV infection

SFDPH Year 1 SMART Objectives

2.2.1. By December 31, 2018, of all persons newly diagnosed with HIV infection, the percentage interviewed for partner services will increase from 61% in 2016 to 68% in 2022.

2.2.2. By December 31, 2018, of all not-in-care persons with previously diagnosed HIV infection, the percentage interviewed for partner services will increase from 0% in 2016 to 15% in 2022.

Activities	*Measures*	*Responsible Position/ Party*	*By When (2018)*
2.2.a. Continue high-yield partner services activities for new positives (also contributes to Outcome 2.1)	See EPMP Measures 2.D.1 – 2.D.4 and 2.2.1 – 2.2.3	LINCS staff	ongoing
2.2.b. Develop plan to expand partner services to not-in-care LINCS navigation clients (also contributes to Outcome 2.1)	Completed plan	Darpun Sachdev	Jun
2.2.c. Use HIV Surveillance data to identify 1) newly diagnosed cases at private providers offices, 2) if newly reported cases to PS are new or known positives, 3) and whether named partners are HIV-negative or positive for PS prioritization.	Priority lists for partner services	Susan Scheer	ongoing

CDC Strategy 3: Maintain HIV transmission outbreak/cluster response plan.

CDC Outcome 3.1: Improved early identification and investigation of HIV transmission clusters and outbreaks

SFDPH Year 1 SMART Objectives

3.1.1. By December 31, 2018, meet standards detailed in the Technical Guidance for HIV Surveillance Programs for early identification and investigation of HIV transmission clusters and outbreaks, assesses as required by CDC standards.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
3.1.a. Analyze surveillance data to identify HIV transmission clusters and outbreaks using Secure HIV-Trace	See EPMP Measure 3.1.1	Mia Chen	ongoing
3.1.b. Prioritize and investigate transmission clusters that are concerning for recent and ongoing transmission	See EPMP Measure 3.1.1	Mia Chen LINCS DCI*	ongoing
3.1.c. Collaborate with other jurisdictions in transmission cluster investigation	Documentation of cross-jurisdictional investigations	Mia Chen LINCS DCI	as needed

*Disease Control Investigator

CDC Outcome 3.2: Improved response to HIV transmission clusters and outbreaks

SFDPH Year 1 SMART Objectives

3.2.1. By December 31, 2018, meet standards detailed in the Technical Guidance for HIV Surveillance Programs for response to selected HIV transmission clusters and outbreaks, assessed as required by CDC.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
3.2.a. For newly identified HIV-positive cluster members: Prioritize for rapid intervention and partner services	See EPMP Measure 2.2.1	Mia Chen LINCS DCI	as needed
3.2.b. For PLWH in transmission clusters who are not virally suppressed: Prioritize for engagement in care services	See EPMP Measure 3.2.1	Mia Chen LINCS DCI	as needed
3.2.c. For partners of transmission cluster members: re-test those not known to be positive within 6 months, and refer HIV-negative persons to PrEP	See EPMP Measures 3.2.2 – 3.2.3	Mia Chen LINCS DCI	as needed

CDC Outcome 3.3: Improved plan and policies to respond to and contain HIV outbreak

SFDPH Year 1 SMART Objectives

3.3.1 By December 2018, develop a plan to maintain capacity for cluster and outbreak detection and response.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
3.3.a. Formalize a written plan for cluster and outbreak detection and response, including work flows, roles of key staff, and a communication plan (with CDC and other partners)	See EPMP Measure 3.3.1	Wayne Enanoria	Jun

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

CDC Outcome 4.1: Increased linkage to and retention in HIV medical care among PLWH

SFDPH Year 1 SMART Objectives

4.1.1 SFDPH will increase the percent of all persons with newly diagnosed HIV infection who are linked to medical care within 1 month from 78% in 2015 to 80% in 2018, as measured by HIV surveillance data.

4.1.2 SFDPH will increase the percent of PLWH retained in HIV medical care by 2% from 2015 to 2018, as measured by HIV surveillance data.

4.1.3 SFDPH will increase the percent of cases referred to LINCS navigation from healthcare providers or identified through surveillance generated not-in-care (NIC) lists that are dispositioned as eligible for navigation (confirmed to be not in care, in care, deceased, or moved), from 37% in 2016 to 45% in 2018, as measured by the number of referrals who were successfully contacted and accepted or refused navigation divided by the number of total referrals.

4.1.4 Among those confirmed to be not in care who are successfully contacted and accept navigation from the DTC NIC list, SFDPH will maintain the percent linked to or re-engaged in medical care from 95% in 2016 to 95% in 2018, as measured by a viral load or CD4 count in surveillance within 180 days of opening navigation assignment.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
Linkage and Retention			
4.1.a. Continue to provide linkage to medical care, treatment, and prevention services, with a focus on populations with the highest disparities in retention and viral load suppression (see also 4.3.a)	Documentation of linkage activities in LINCS and PHAST databases	LINCS staff PHAST staff	ongoing
Systems and Structural Change Approaches			
4.1.b. Implement planning process to align Ryan White services with retention services continuum	Report on outcomes of planning process	Darpun Sachdev	Sep
4.1.c. Partner with SFHN to identify risk factors for falling out of care, to inform HIV retention panel management	Risk factor analysis	Darpun Sachdev	Sep
4.1.d. Increase linkage to care/navigation capacity among CBOs, Onsite linkage/partner services at sites	Facilitate 2 navigator network meetings	Darpun Sachdev	Sep
4.1.e. Develop a protocol for and incorporate retention planning into LINCS protocols for newly diagnosed	Written protocol	Darpun Sachdev	Jun
Data to Care			

4.1.g. Continue to provide a monthly surveillance-generated NiC list to the LINCS Team, of HIV-positive individuals potentially not in care or other prioritized groups, such as persons experiencing viral failure, those with early infection, and those in transmission clusters	See EPMP Local Measure 4.A.1	Susan Scheer	ongoing
4.1.h. Update data sharing agreements between HIV Surveillance, LINCS, and CBOs for sharing client-level data for PLWH	Updated written and signed agreements	Wayne Enanoria	Mar
4.1.i. Incorporate LINCS and PHAST team data into HIV surveillance data, including updating any missing information such as (e.g., address, demographics)	Increased completeness of surveillance data	Ling Hsu Darpun Sachdev PHAST Team	ongoing

CDC Outcome 4.2: Increased early initiation of ART among PLWH

SFDPH Year 1 SMART Objectives

4.2.1 SFDPH will decrease the median number of days from diagnosis to viral suppression, from 51 days in 2016 to 45 days in 2018.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
4.2.1 Implement public health detailing to educate medical providers and frontline workers about RAPID	See EPMP Local Measure 4.2.1	Darpun Sachdev	ongoing

CDC Outcome 4.3: Increased HIV viral load suppression among PLWH

SFDPH Year 1 SMART Objectives

4.3.1 SFDPH will increase the percent virally suppressed from 72% in 2015 to 80% in 2018.

4.3.2 SFDPH will increase the percent of NIC PLWH linked to HIV medical care through LINCS navigation activities who achieved viral suppression within 6 months after linkage/re-engagement, from 57% to 62%.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
4.3.a. Continue to provide linkage to medical care, treatment, and prevention services, with a focus on populations with the highest disparities in retention and viral load suppression (see also 4.1.a)	Documentation of linkage activities in LINCS and PHAST databases	LINCS staff PHAST staff	ongoing

CDC Outcome 4.4: Decreased risk behaviors among PLWH at risk of transmission

SFDPH Year 1 SMART Objectives

4.4.1 By December 31, 2018, 85% of all persons testing positive for HIV in EvaluationWeb who are screened and identified as needing risk reduction will be referred to Shanti, Positive Force, or another prevention with positives program.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
4.4.a. Continue to support community-based prevention with positives programs at the San Francisco AIDS Foundation (SFAF) and Shanti.	# of cycles of the Life Program implemented (Shanti) # of PLUS Seminars implemented (SFAF)	John Melichar	ongoing
4.4.b. Issue community-based HIV prevention RFP, which will include evidence-based non-biomedical risk reduction programs for PLWH, with a focus on disparities and stigma.	RFP publication	Tracey Packer	Sep

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

CDC Outcome 5.1: Increased referral of persons eligible for PrEP
CDC Outcome 5.2: Increased linkage of persons eligible for PrEP to PrEP providers
CDC Outcome 5.3: Increased prescription of PrEP to persons for who PrEP is indicated

SFDPH Year 1 SMART Objectives

5.1.1. By December 31, 2018, SFDPH and its funded community-based PrEP programs will start 318 people on PrEP, as measured by self-report of first dose, or if that is not possible, documentation of prescription.

5.1.2. By December 31, 2018, 60% of all persons enrolled in community-based PrEP programs will start PrEP, as measured by program enrollment records and self-report of first dose.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
5.1.a. Work with CBOs and the HCPC to identify solutions to barriers to accessing/staying on PrEP.	At least 1 discussion with CBOs; at least 1 discussion with HCPC	Thomas Knoble Jose Luis Guzman	Jun
5.1.b. Continue to train HIV test counselors to refer to PrEP	Training curriculum	Thomas Knoble	ongoing
5.1.c. Continue to support 7 community-based PrEP programs for the following populations: 3 programs for high prevalence populations (MSM, PWID, trans female), 1 for Black MSM, 1 for Latino MSM, 1 for trans women, and 1 for young MSM*	# of community engagement/out reach events	Nikole Trainor (in kind)	ongoing
5.1.d. Data to PrEP Implement panel management protocols at the SF City Clinic PrEP program program to identify clients who are not retained in the program and reach out to understand reasons for stopping PrEP and offer assistance with re-linkage or retention	# of clients reached	Stephanie Cohen	
5.1.e. Continue to offer PrEP through City Clinic, SFHN primary care, youth Truvada access program, and pharmacy-based PrEP pilot programs	# of clients reached	Stephanie Cohen Nikole Trainor (in kind)	ongoing
5.1.f. Monitor and evaluate all PrEP program outcomes, identify areas for improvement, and make data-informed	Documentation of decisions and supporting data	Susan Scheer Dara Geckeler	Jul

decisions regarding what to continue after Project PrIDE ends in September 2018			
5.1.g. Standardize the partner services protocols for providing linkage to PEP and PrEP for all (and their HIV-negative partners) and HIV-negative partners of newly diagnosed HIV cases	Written protocols # of clients referred from partners services to PrEP navigation	Darpun Sachdev Stephanie Cohen	Jun
5.1.f. Implement public health detailing to educate medical providers about PrEP	# of detailing visits	Darpun Sachdev	Sep

*These programs provide a full spectrum of PrEP-related efforts, including community outreach to increase awareness, eligibility screening, benefits navigation, linkage to PrEP, provision of PrEP, follow-up and adherence support for at least 6 months, and linkage to other support services (such as substance use and housing).

CDC Outcome 5.4: Decreased sexual risk behavior among HIV-negative persons at for HIV infection and other STDs

SFDPH Year 1 SMART Objectives

5.4.1 By December 31, 2018, 100% of SFDPH-funded CBOs providing risk reduction interventions for HIV-negative persons will meet their contractual deliverables for number of contacts and units of service.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
5.4.a. Continue to support CBOs providing risk reduction interventions for HIV-negative persons focused on MSM, Black MSM, Latino MSM, trans women, and substance users, including referrals to essential support services and PrEP	Maintain level of service provision	Katie Burk Oscar Macias John Melichar Nyisha Underwood	ongoing
5.4.b. Collaborate with HIV community-based organizations (CBOs) and the HCPC to develop a plan for aligning risk reduction programs for HIV-negative persons with the current epidemiology	At least 3 input/planning meetings with CBOs; at least 1 discussion on with HCPC	John Melichar Jose Luis Guzman	Jun
5.4.c. Provide capacity-building assistance to HIV prevention CBOs to align programs with plan identified in 5.4.b.	Documentation of CBA provided	Katie Burk Oscar Macias John Melichar Nyisha Underwood	Aug

5.4.d. Continue to scale up and integrate HCV and STD prevention into HIV risk reduction interventions.	Risk reduction curricula include HCV and STD prevention	Katie Burk Brandon Ivory	ongoing
5.4.e. Issue community-based HIV prevention RFP, which will include risk reduction interventions for HIV-negative persons	RFP publication	Tracey Packer	Sep

CDC Strategy 6: Conduct perinatal prevention and surveillance activities.

CDC Outcome 6.1: Reduced perinatally acquired HIV infection

CDC Outcome 6.2: Increased number of pregnant women who are aware of their HIV status

SFDPH Year 1 SMART Objectives

6.1.1. San Francisco will maintain 0 perinatal HIV infections in 2018, marking the 13th consecutive year of eliminating perinatally acquired HIV.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
6.1.a. Promote routine, perinatal HIV testing of all pregnant women per CDC recommendations.	Documentation of collaboration with the UCSF HIVE Program (see attached letter of support)	UCSF HIVE Program (in kind) LINCS staff	ongoing

CDC Outcome 6.3: Improved completeness, timeliness, and quality of perinatal HIV surveillance data (for case and exposure reporting)

SFDPH Year 1 SMART Objectives

6.3.1. By December 31, 2018, include data and trend analyses of children diagnosed with HIV infection in the HIV Epidemiology Report.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
Because SF has not had a case of perinatally transmitted HIV since 2005, SF is requesting to opt out of specialized perinatal HIV surveillance activities, including Perinatal HIV Exposure Reporting and Fetal Infant Mortality Review. Should the epidemiology change, SFDPH will update the work plan.			

CDC Strategy 7: Conduct community-level HIV prevention activities.

CDC Outcome 7.1: Increased availability of condoms among persons living with or at risk for HIV infection.

SFDPH Year 1 SMART Objectives

7.1.1. By December 31, 2018, SFDPH and its community partners will maintain the number of condoms distributed, at 1.6 million.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
7.1.a Continue citywide condom distribution program (agencies/businesses can request free condoms from SFDPH)	See EPMP Measure 7.1.1	Betty Lew	ongoing
7.1.b. Distribute condoms and safer sex supplies at community venues such as bars and events and health fairs, such as Carnival, Pride, and Folsom Street Fair.	See EPMP Measure 7.1.1	John Melichar	ongoing
7.1.c. Continue to provide condom distribution at SFDPH clinics and SFDPH-funded HIV prevention programs	% of SFDPH clinics distributing condoms	John Melichar	ongoing
7.1.d. Collaborate with SFDPH Healthy Retail program to improve access to condoms in high-prevalence neighborhoods (working with retailers to address pricing, behind counter location, and other barriers)	Capacity-building assistance to at least 1 retail outlet	Jacque McCright Brandon Ivory	Dec

CDC Outcome 7.2: Increased awareness in affected communities at risk for transmitting or acquiring HIV infection and strategies for reducing these risks

SFDPH Year 1 SMART Objectives

7.2.1 Implement at least one social marketing campaign to increase awareness regarding HIV-related topics relevant to the current community context

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
7.2.a. Implement a social marketing campaign to address the use of condoms in the era of PrEP (funded by Project PrIDE)	See EPMP Measure 7.2.2	Nikole Trainor (in kind)	Dec
7.2.b. Begin formative research for a social marketing campaign addressing PrEP persistence, especially among communities	Formative research report	John Melichar	Dec

with no or intermittent/ frequently changing access to insurance			
7.2.c. Develop a plan for youth-focused social media approaches to HIV prevention	Plan developed	John Melichar	Dec
7.2.d. Work with the HCPC and other community partners to develop innovative strategies for reaching and mobilizing communities of color	See EPMP Measure 7.2.1	John Melichar	Jun

CDC Outcome 7.3: Increased access to syringe service programs for persons who inject drugs

SFDPH Year 1 SMART Objectives

7.3.1 By 2018, SFDPH's funded syringe services program will maintain the number of service sites at 12.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
7.3.a. Continue to support San Francisco AIDS Foundation and its community-based subcontractors to provide syringe access and disposal programs throughout SF	See EPMP Measure 7.3.1 (Local target: 12 sites)	Eileen Loughran	ongoing
7.3.b. Continue to expand disposal options, including large kiosks and wall-mounted disposal boxes placed in "hot spots".	# of types of disposal options	Eileen Loughran	ongoing
7.3.c. Continue to outreach and convene focus groups to engage with community of users about syringe disposal	# of focus groups	Eileen Loughran	ongoing
7.3.d. Continue to engage with communities and neighborhoods regarding importance of syringe services	# of neighborhood associations/ community groups who have engaged in dialogue with SFDPH	Eileen Loughran	ongoing
7.3.e. Continue to develop DPH Community Health Response Team to address syringe disposal issues	# of syringes collected by Team	Jose Luis Guzman	ongoing
7.3.f. Continue to pilot syringe access and disposal services at homeless encampments	Peer camp liaisons collect and return containerized syringes after	Peer camp liaisons	ongoing

	encampment events		

CDC Outcome 7.4: Reduced stigma and discrimination for persons with diagnosed HIV infection

SFDPH Year 1 SMART Objectives

7.4.1 By December 2018, in collaboration with Getting to Zero, SFDPH will establish standard indicators for assessing trends in HIV-related stigma using data from Medical Monitoring Project, an NIH-funded PrEP supplement to Project PRIDE, National HIV Behavioral Surveillance, and other sources.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
7.3.a. Collaborate with Getting to Zero Stigma Committee to identify and prioritize and fund stigma interventions	See EPMP Measure 7.4.1	Tracey Packer	Dec
7.3.b. Collaborate with Getting to Zero Stigma Committee to measure HIV-related stigma	See EPMP Measure 7.4.1	Susan Scheer	ongoing
7.3.c. Ensure that all community-based HIV prevention programs integrate stigma-related assessment and interventions into their programs	See EPMP Measure 7.4.1	John Melichar	ongoing

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

CDC Outcome 8.1: Increased coordination of, availability of, and access to comprehensive HIV prevention, treatment and support services

SFDPH Year 1 SMART Objectives

8.1.1. By 2018, 80% of HCPC members will report basic knowledge about HIV prevention and HIV care/Ryan White.

8.1.2. By 2018, 80% of HCPC members will "agree" or "strongly agree" that they have sufficient knowledge of HIV services across care and prevention providers in San Francisco.

8.1.3. By October 2018, the HCPC will complete a review of and recommend updates to the Integrated HIV Prevention and Care Plan.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
8.1.a. Continue to maintain partnership with the HCPC and build Council members' capacity to participate in integrated planning	See EPMP Measure 8.1.1	Tracey Packer Jose Luis Guzman Darpun Sachdev	ongoing
8.1.b. Write, submit, and disseminate an updated SF EMA Integrated HIV Prevention and Care Plan, incorporate HCPC recommendations.	Updated plan submitted to CDC by due date	Jose Luis Guzman Dean Goodwin (in kind) HCPC	Dec
8.1.c. Monitor the SF EMA Integrated HIV Prevention and Care Plan.	Integrated plan implementation grid updated quarterly	Nyisha Underwood	ongoing
8.1.d. Develop a combined SF HIV prevention and care networks resource website	Updated HIV prevention and care resources inventory	Jose Luis Guzman Dean Goodwin (in kind)	Oct

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

CDC Outcome 9.1: Increased data security, confidentiality, and sharing

SFDPH Year 1 SMART Objectives

9.1.1 By December 31, 2018, SFDPH will achieve full compliance with NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011).

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
9.1.a. Ensure SFDPH staff and funded contractors are trained in the local SFDPH data and confidentiality standards (which comply with NCHHSTP standards)	Certificates of completion of annual HIPAA training in place for all CDC-funded SFDPH staff Current signed Business Associate Agreements in place for all contractors (See also EPMP Measure 9.1.1)	Susan Philip Tracey Packer Wayne Enanoria SFDPH Business Office	ongoing
9.1.b. Maintain secure procedures for data sharing, including D2C activities and use of Medical Monitoring Project (MMP) data across HIV programs, within the context of existing laws	Data sharing agreements in place for all collaborative partnerships	Wayne Enanoria	ongoing
9.1.c. Promote expansion of technological advances to enhance HIV surveillance, testing, data analysis and sharing, such as HIV-Trace	Documentation of use of or transition to new technologies	Susan Scheer	ongoing
9.1.d. Ensure that all CDC provided software releases and upgrades are installed within required timeframes	Installations completed on time	Wayne Enanoria	ongoing

CDC Outcome 9.2: Reduced systemic, legal, regulatory, policy, organizational, operational, social, or cultural barriers to HIV surveillance, prevention and care.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
9.2.a. Support efforts to align existing structures, policies, and rules to create an enabling environment for optimal HIV surveillance, prevention, care, and treatment.	See EPMP Measure 9.2.1	Tracey Packer Susan Philip Susan Scheer	ongoing
9.2.b. Collaborate with public and private sector health systems, pharmacies, and health plans to share data on PrEP uptake and utilization	See EPMP Measure 9.2.1	Darpun Sachdev	ongoing

CDC Strategy 10: Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV prevention, surveillance, and care activities.

CDC Output 10.A: Increased use of data to plan, monitor, evaluate and improve HIV surveillance and HIV prevention programs and monitor the impact of local HIV prevention efforts.

SFDPH Year 1 SMART Objectives

10.1.1. By December 2018, SFDPH will produce a continuum of care analysis using National HIV Surveillance System standards, and publish it in the annual report and integrated Epidemiologic Profile.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
10.A.a. Develop detailed 5-year work plan for CDC NOFO 18-1802	Plan completed and submitted to CDC	Tracey Packer Susan Philip Susan Scheer	Jun
10.A.b. Develop a local evaluation and performance measurement plan using the Results-Based Accountability framework and that meets CDC requirements	Plan completed and submitted to CDC	Dara Geckeler	Jun
10.A.c. Issue community-based HIV prevention RFP, to shift services to align with the most current epidemiological, surveillance, and other available data sources	RFP publication	Tracey Packer	Aug
10.A.d. Track HIV prevention program data using EvaluationWeb and Results Scorecard (clearimpact.com)	EvaluationWeb and Results Scorecards reviewed quarterly by SFDPH staff and funded programs	John Melichar Dara Geckeler Darpun Sachdev	Quarterly, ongoing
10.A.e. Report annually to CDC on the amount of funding allocated to the areas with 30% or greater of the HIV prevalence and how the funds were used (for SF, this will be data for the entire City and County of SF)	Annual report submitted to CDC	Michael Paquette	Dec

CDC Outcome 10.1: Increased coordination and integration of comprehensive HIV prevention and care services.

SFDPH Year 1 SMART Objectives

10.1.1. By December 31, 2018, SFDPH HIV prevention and Ryan White staff will hold at least 4 meetings to discuss opportunities for improved coordination and integration.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
10.1.a. Monitor the SF EMA Integrated HIV Prevention and Care Plan. (Also contributes to Outcome 8.1)	Excel activity tracking sheet updated quarterly	Nyisha Underwood	Quarterly, ongoing
10.1.b. Implement planning process to align Ryan White services with retention services continuum (Also contributes to Outcome 4.1)	Report on outcomes of planning process	Darpun Sachdev	Sep

CDC Outcome 10.2: Improved targeting of HIV testing, prevention, and care resources, funding, and services.

CDC Outcome 10.3: Improved targeting, prioritization, and effectiveness of funded HIV prevention activities.

CDC Outcome 10.4: Improved targeting of HIV programs to address HIV-related health disparities.

SFDPH Year 1 SMART Objectives (for CDC Outcomes 10.2 – 10.4)

10.2.1 By September 30, 2018, SFDPH will issue an RFP for community-based HIV prevention services that solicits services in line with the most current epidemiology and HIV-related disparities.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
10.2.a. Continue current community-based services (including HIV testing) for 2018, while planning for shifts to align with current epidemiology	% of all tests that were among persons at high risk for HIV infection	Tracey Packer John Melichar	Dec
10.2.b. Disseminate 2017 Annual HIV Epidemiology report to stakeholders, including posting on website and presenting	Dissemination plan; HCPC	Susan Scheer Jose Luis Guzman	Mar

data trends to HCPC (Also contributes to Outcome 1.1)	presentation prepared		
10.2.c. Collaborate with HIV community-based organizations (CBOs) and the HCPC to develop a plan for shifting the community-based HIV prevention strategy to align with the current epidemiology (see narrative; Also contributes to Outcome 2.1)	At least 3 input/planning meetings with CBOs; at least 1 discussion on with HCPC	Thomas Knoble	June
10.2.d. Provide capacity-building assistance to HIV prevention CBOs to align programs with current epidemiology. (Also contributes to Outcome 2.1)	Documentation of CBA provided	CHEP Program Liaisons; LINCS	ongoing
10.2.e. Issue community-based HIV prevention RFP (Also contributes to Outcome 2.1)	RFP publication	Tracey Packer	Sep
10.2.f. Public health detailing for medically based HIV testing in EDs, urgent care, and primary care (Also contributes to Outcome 2.1)	# of detailing presentations with emergency departments, hospitalists, and primary care providers city-wide	Darpun Sachdev	Sep

CDC Strategy 11: Build capacity for conducting effective HIV program activities, epidemiological science, and geocoding.

CDC Outcome 11.1: Strengthen interventional surveillance and response capacity

SFDPH Year 1 SMART Objectives

11.1.1. By December 31, 2018, maintain capacity for interventional surveillance and response.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
SFDPH currently has the capacity for all activities listed in the NOFO. EPMP Measures for Strategy 11.1 apply, and Susan Scheer and Ling Hsu are the responsible parties for all activities.			

CDC Outcome 11.2: Enhanced knowledge of the influence of social determinants on risk for disease and continuum of care outcomes

SFDPH Year 1 SMART Objectives

11.1.2. By September 30, 2018, publish the 2017 HIV Epidemiology Annual report, which will include 5 years of trends for new HIV diagnoses, deaths and people living with HIV and 4 years of trends for HIV indicators along the HIV care continuum (linkage to care, retention in care and viral suppression). *[see also SFDPH Objective 1.1.1]*

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
11.1.a. Conduct analysis of geocoded HIV surveillance data and produce maps that identify patterns between HIV morbidity and social determinants of heath for targeting testing and treatment activities.	See EPMP Measure 1.B.1	Ling Hsu Susan Scheer	Sep
11.1.b. Conduct analysis of surveillance data and produce maps, tables, and figures that identify patterns between HIV morbidity and social determinants of heath for all items on the care continuum.	Maps, tables, and figures addressing social determinants of health	Ling Hsu Susan Scheer	Sep
11.1.c. Disseminate analyses in the Integrated Epidemiologic Profile, the annual HIV surveillance report, and presentations to HCPC and community partners to inform testing and treatment activities.	See EPMP Measure 1.1.1b and 1.A.1	Susan Scheer Tracey Packer	Dec

CDC Output 11.A: Increased capacity-building support and technical assistance provided within the jurisdiction (including CBOs and other partners)

SFDPH Year 1 SMART Objectives

11.1.3. By December 2018, all currently funded HIV prevention CBOs will received capacity-building assistance to shift their programs to align with the current epidemiology.

Activities	*Measures*	*Responsible Position/Party*	*By When (2018)*
11.A.1. Develop and implement a capacity building assistance plan for SFDPH community-based providers, and clinical providers (including public health detailing).	See EPMP Measures 11.A.1 – 11.A.2	Michael Paquette	Jun
11.A.2. Provide capacity-building assistance to HIV prevention CBOs to align programs with current epidemiology. (Also contributes to Outcomes 2.1 and 10.2)	Documentation of CBA provided	CHEP Program Liaisons; LINCS	ongoing
11.A.3. Collaborate and leverage partners including the Pacific AIDS Education and Training Center, the California STD/HIV Prevention Training Center, UCHAPS, NASTAD, and CDC-funded CBA providers to offer capacity building assistance, training, and technical assistance to HIV prevention service providers and other prevention agencies and partners.	Documentation of CBA, training, and technical assistance provided	CHEP Program Liaisons	ongoing
11.A.4. Ensure that all health department staff are appropriately trained for their respective job responsibilities under this program.	Certificates of training completion	Tracey Packer Susan Philip Susan Scheer	ongoing
11.A.5. Promote Results Scorecard (clearimpact.com) as a mechanism to share relevant HIV data with community partners and planning groups.	Partners have access to relevant scorecards	Dara Geckeler	ongoing
11.A.6. Facilitate exchange of information and peer-to-peer consultation and TA among sites for HIV testing (HIV Testing Coordinators Group), PrEP navigators (Citywide PrEP Navigators Group), and retention (Frontline HIV Workers Group).	Best practices identified and implemented	Testing – Thomas Knoble PrEP – TBH Retention – Andy Scheer	ongoing