File No. 120910

Committee Item No. 8
Board Item No. 15

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget and Finance Committee **Date** 10/03/2012

Board of Supervisors Meeting **Date** October 16, 2012

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Completed by: Victor Young **Date** September 28, 2012
Completed by: Victor Young **Date** 10/2/12

FILE NO. 120910 RESOLUTION NO.

[Approval of the Comprehensive HIV Prevention Programs Application - $9,523,313]

Resolution authorizing the San Francisco Department of Public Health to submit a one-year application for calendar year 2013 to continue to receive funding for the Comprehensive HIV Prevention Programs grant from the Centers for Disease Control and Prevention, requesting $9,523,313 in HIV prevention funding for San Francisco; from January 1, 2013, through December 31, 2013.

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

WHEREAS, San Francisco Department of Public Health (SFDPH) is currently a recipient of the "Comprehensive HIV Prevention Programs" grant in the amount of approximately $ 8,085,800 from the Centers for Disease Control and Prevention (CDC) for calendar year 2012; and

WHEREAS, For this round of funding, SFDPH was instructed by the CDC to submit a one-year application request, with a budget for 2012 that is identical to last year's budget, with the budget for 2013 to be determined and sent next year when the CDC sends additional instruction to counties; and

WHEREAS, SFDPH uses these funds to cover a multitude of HIV prevention programs for San Francisco residents, which includes planning, evaluation, coordination of programs, and contract management and the remaining funds subcontracted to qualified contractors selected through Request For Proposals to provide direct services to clients; and

WHEREAS, the funds to qualified contractors are established in the categories of HIV Testing, Health Education and Risk Reduction to Address Drivers, Prevention with Positives, and Special Projects to Address HIV-Related Disparities for the following behavioral risk population groups; and

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

WHEREAS, The CDC released the application announcement on July 24, 2012 with a due date of September 28, 2012 allowing just 60 days for the entire process; and

WHEREAS, in the interest of timeliness, SFDPH is making this request for approval by submitting last year's application for the Comprehensive HIV Prevention Programs grant funding from the CDC, also including supporting documents as required, all of which are on file with the Clerk of the Board of Supervisors in File No. 120910, which is hereby declared to be part of the Resolution as if set forth fully herein; and, now, therefore, be it

RESOLVED, that the Board of Supervisors hereby approves SFDPH application submission to the CDC for the "Comprehensive HIV Prevention Programs" grant for funding in 2013, to be submitted no later than September 28, 2012.

RECOMMENDED:

Barbara A. Garcia, MPA
Director of Health

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

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

Funding Source's Grant Criteria
The San Francisco Department of Public Health is currently a recipient of the HIV Prevention Project grant in the amount of $9,525,313 from the Centers for Disease Control and Prevention (CDC), Department of Health & Human Services. The grant is awarded to the City and County of San Francisco.

Applications may be submitted by state, local and territorial health departments or their Bona Fide Agents. This includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands, and Republic of Palau. Also eligible are the local (county or city) health departments serving the 10 specific Metropolitan Statistical Areas (MSAs) or specified Metropolitan Divisions (MDs) that have the highest unadjusted number of persons living with a diagnosis of HIV infection as of year-end 2008.

Department's Most Recent Draft of Grant Application Materials
Year 2013 application announcement for the CDC Comprehensive HIV Prevention Programs for Health Departments grant has been issued to the Department on July 24, 2012 and due on September 28, 2012. Thus please see Attachment A for the latest HIV Prevention Project application materials dated September 13, 2011 for calendar year 2012.

Anticipated Funding Categories That The Department Will Establish In The Subsequent Request For Proposals (RFPs) Process
The funds are awarded to the Department on an annual basis to cover a multitude of HIV prevention programs for San Francisco residents. The funds are utilized to support direct services (both those provided by the Department, as well as those subcontracted to qualified contractors selected through RFP), planning, evaluation, community engagement, coordination of programs, and contract management.
The funds to qualified contractors are established in the categories of HIV Testing, Health Education and Risk Reduction to Address Drivers, Prevention with Positives, and Special Projects to Address HIV-Related Disparities for the following behavioral risk population groups:

Behavioral Risk Population (BRP) Definitions Table

Behavioral Risk Populations (BRPs)	
BRP #	BRP Definition
BRP 1	Males Who Have Sex With Males, Males Who Have Sex With Males and Females, and Transmales who have sex with males.
BRP 2	Injection Drug Users
BRP 3	Transfemales who have sex with males

Comments From Any Relevant Citizen Advisory Body

The HIV Prevention Planning Council (HPPC) writes the HIV Prevention Plan, upon which the application for funding is based and all RFPs are based. A list of the HPPC members is included in Attachment B.

Project Abstract Summary

Project Summary

The San Francisco (SF) Division seeks funds for four projects as follows: Continuum of HIV Prevention, Care, and Treatment (Category A), Expanded Testing Initiative (Category B), Augmenting High-Impact Prevention (A-HIP): Maximizing Outcomes Along the Continuum of Care (Category C), and Project DRINK-SMART: Reducing the Impact of Heavy Alcohol Use on HIV Incidence (Category C).

Continuum of HIV Prevention, Care, and Treatment (Category A): San Francisco, Marin, and San Mateo Counties propose to implement a comprehensive Continuum of HIV Prevention, Care, and Treatment services for people living with and at risk for HIV. Populations at risk include males who have sex with males (MSM), injection drug users (IDUs), and transfemales who have sex with males (TFSM). Services will include HIV testing in community-based and medical settings, comprehensive prevention with positives, evidence-based interventions for HIV-negative people, condom distribution, syringe access and disposal, and policy interventions. The objectives are: 1) to increase status awareness and reduce undiagnosed HIV infection rates, 2) to increase viral load suppression among HIV-positive people to reduce risk of transmission, 3) reduce sexual and injection-related risk behavior, and 4) to increase health equity.

Expanded Testing Initiative (Category B): This project will be implemented in the City and County of San Francisco. The overarching goal of this project is to increase the number of patients who receive annual HIV screening and the number and proportion of HIV-infected persons who are aware of their infection among populations disproportionately affected by HIV through routine HIV screenings in healthcare settings. Activities will include providing training and technical assistance to clinics, working to incorporate HIV testing into continuous quality improvement processes at clinics, and social marketing. All patients testing HIV-positive will be linked to HIV primary care and offered partner services.

A-HIP (Category C): This project will be implemented in the City and County of San Francisco and will strengthen San Francisco's current Continuum of Prevention, Care, and Treatment with technological strategies to better reach populations disproportionately affected by HIV. The focus is on using technology to increase testing and viral suppression rates, which if maximized could reduce HIV incidence. Project activities include the development of a data system that will "trigger" interventions, such as a text message to remind a person that it is time to get an HIV test. Objectives include: 1) to increase status awareness and reduce undiagnosed HIV infection rates, 2) to increase viral load suppression among HIV-positive people, and 3) to increase health equity.

Project DRINK-SMART (Category C): This project will develop and evaluate new "high impact" HIV prevention interventions addressing heavy alcohol use among MSM who account for nearly 90% of new infections in San Francisco. Strategies include a behavioral intervention called Personalized Cognitive Counseling (PCC), as well as structural interventions to reduce the availability of alcohol (such as training of alcohol servers). In addition, HIV testing will be provided at bars frequented by MSM. Objectives for PCC are as follows: (1) reduced heavy alcohol use among 50% of participants; (2) reduced unprotected anal sex while under the influence of alcohol among 50% of participants; (3) increased testing frequency; and (4) increased linkage to and retention in care. The objective of the alcohol server training is increased self-reported capacity to conduct assessment and interventions among bartenders. The objectives of testing in bars are to increase (1) status awareness, (2) HIV diagnoses, and (3) linkage to and retention in care.

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

79817

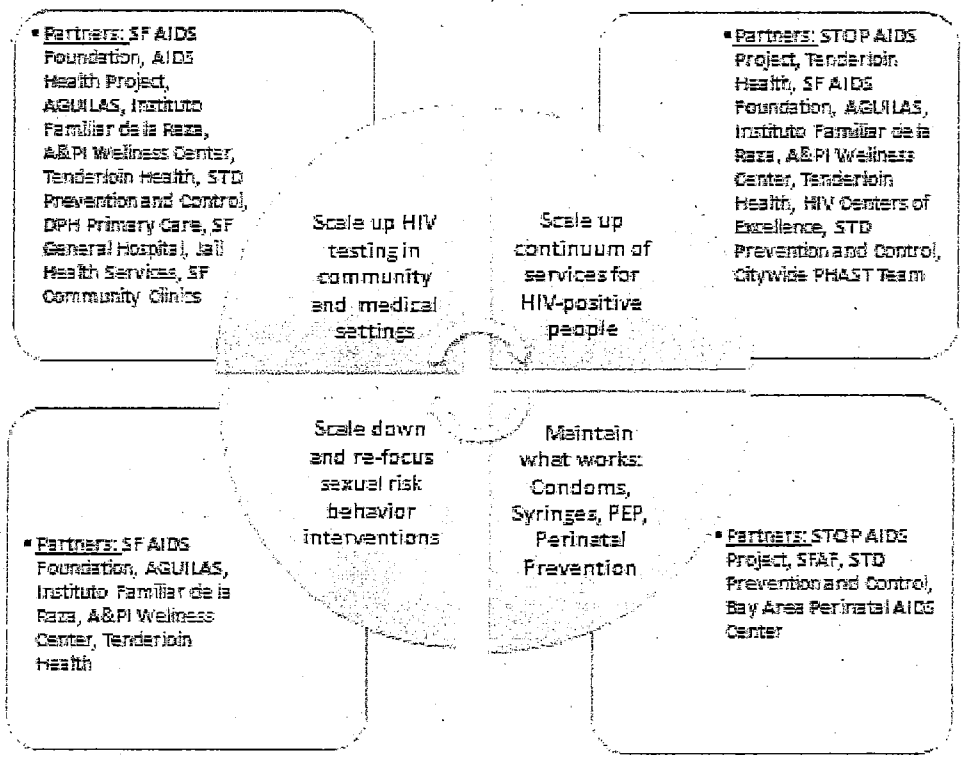
Attachment B
San Francisco Department of Public Health - HIV Prevention Section
HIV Prevention Planning Council Membership List - Year 2012

	YEAR 2012 HPPC Member List			
	Non-Appointed Seats			
1	HPPC Member	Mr	Sean	Arayasirikul
2	HPPC Member	Ms	Erin	Armstrong
3	HPPC Member	Mr	Richard	Bargetto
4	HPPC Member	Mr	Jackson	Bowman
5	HPPC Member	Ms	Gayle	Burns
6	HPPC Member	Ms	Claudia	Cabrera-Lara
7	HPPC Member	Ms	Chadwick	Campbell
8	HPPC Member	Mr	Ed	Chitty
9	HPPC Member	Mr	Michael	Discepola
10	HPPC Member	Mr	David	Gonzalez
11	HPPC Member	Mr	Jose Luis	Guzman
12	HPPC Member	Mr	Paul	Harkin
13	HPPC Member	Mr	Andrew	Lopez
14	HPPC Member	Mr	Aja	Monet
15	HPPC Member	Ms	Jessie	Murphy
16	HPPC Member	Ms	Gwen	Smith
	Appointed Seats			
17	DPH Co-Chair	Ms	Tracey	Packer
18	CBHS	Ms	Nan	O'Connor
	CBHS (Alternate)	Ms	Susan	Esposito
19	Community-Oriented Primary Care	Mr	Bill	Blum
	Community-Oriented Primary Care (Alternate)			To be hired
20	HIV Health Services Planning Council	Ms	Laura	Thomas
	HIV Health Services Planning Council (Alt)	Mr	Michael	Scarce
21	Housing	Mr	Bruce	Ito
	Housing (Alternate)	Mr	Brian	Cheu
22	Jail Health Services	Ms	Kate	Monico Klein
	Jail Health Services (Alt)	Ms	Isela	González
23	STD Prevention & Control	Mr	Frank	Strona
	STD Prevention & Control (Alternate)	Mr	Charles	Fann
	Non-Voting Seats			
	Marin County	Ms	Chris	Santini
	Marin County (Alt)	Ms	Cicily	Emerson
	San Mateo	Ms	Darryl	Lampkin
	San Mateo (Alt)	Mr	Eduardo	Moreira-Orantes

Overview of Application

San Francisco (SF) has an ambitious and achievable goal of reducing new HIV infections by 50% by 2017. The 2010 San Francisco HIV Prevention Plan outlines a bold strategy for realizing this vision. The SF Department of Public Health (SFDPH) HIV Prevention Section (HPS) put this Plan into action with the release of the 2010 request for proposals (RFP) for community-based services, with new contracts starting 9/1/11. Simultaneously, HPS built collaborations within SFDPH to enhance internal capacity to meet prevention needs.

Exhibit 1: The SF Model for HIV Prevention

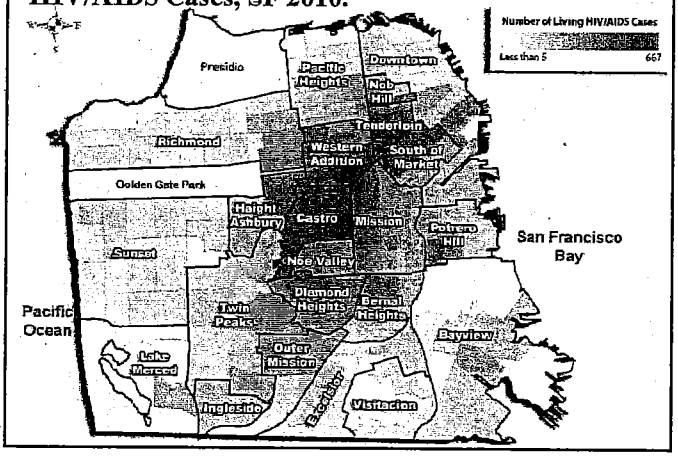


This application's jurisdiction is the SF Metropolitan Division, consisting of the City and County of SF, Marin County, and San Mateo County. Because nearly 90% of HIV/AIDS cases are in SF, the narrative focuses on SF. Additional information on Marin and San Mateo County are in Attachment 1.

This application describes SF's entire approach to HIV prevention, to illustrate the comprehensiveness, scope, and integrated nature of the SF HIV prevention effort. In addition to support from Category A, SF will leverage funding from other sources (such as Categories B and C of this application, SF General Fund, and Enhanced Comprehensive HIV Prevention Planning and Implementation (ECHPP) funds) to support the efforts described here.

A. Background and Need

Exhibit 2. Geographic Distribution of Living HIV/AIDS Cases, SF 2010.



1. Brief description of the overall HIV epidemic within the Metropolitan Division. The City and County of SF is a seven by seven square mile city with a population of 815,358.[1] HIV prevalence in SF is estimated at 2.27%, the highest in the Division. As of 2011, an estimated 18,576 people are living with HIV/AIDS in SF.[1]

2. Divisions within the jurisdiction with >30% of persons living with HIV. Within the Metropolitan Division, almost 90% of persons living with HIV are residents of SF. Within SF, the neighborhoods with the greatest concentration of HIV are the Castro, Western Addition, Tenderloin, and South of Market neighborhoods, as can be seen in Exhibit 2 above.

3. Highest risk populations in the target area. The populations most at risk for acquiring or transmitting HIV are detailed in Exhibit 3, and include males who have sex with males (MSM), injection drug users (IDU), and transfemales who have sex with males (TFSM). Together, these three populations represent 91% of HIV/AIDS cases and an estimated 96% of the 723 annual new HIV infections in SF.[1, 2] Different behaviors and contexts drive HIV within each of these

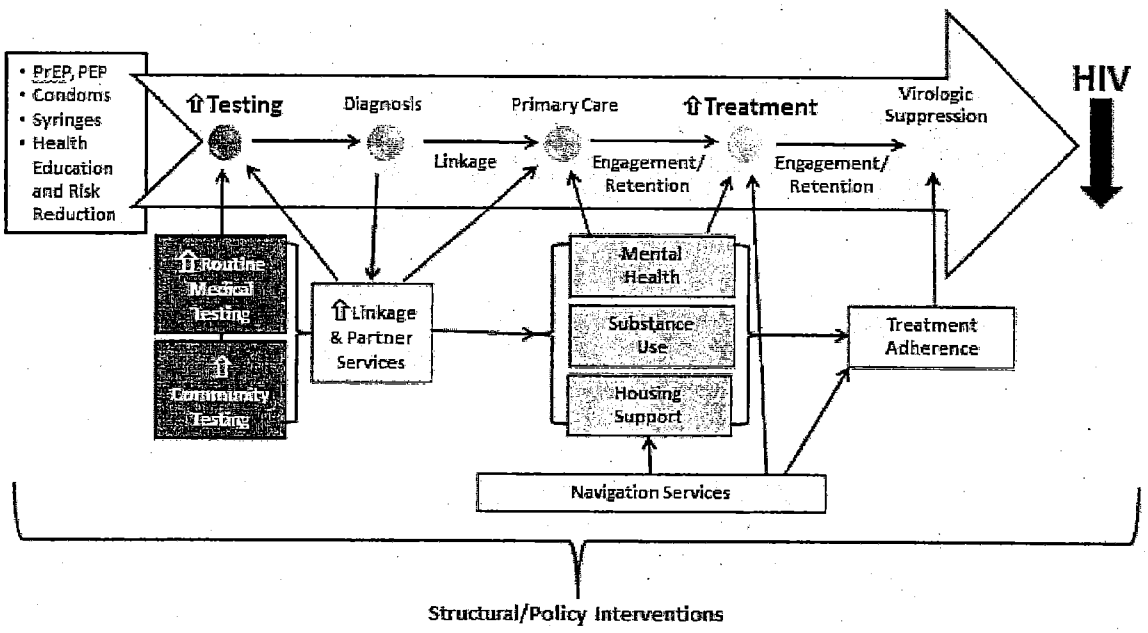
different populations (Exhibit 3). Unprotected anal sex is the primary behavior responsible for HIV infections in SF, and substance use has been directly linked to HIV seroconversion among MSM. Non-sexual behaviors, such as late/non-testing, treatment non-adherence among HIV-positive people, and missed HIV primary care appointments also contribute to new infections by limiting status awareness and decreasing opportunities to suppress viral loads. Social determinants of these behaviors, including stigma, racism, and homophobia, create an environment that is not supportive of healthy behaviors.

Population	Epidemiologic Data [1-5]	Behaviors, Social Determinants, and Contexts [3]
MSM, including MSM who inject drugs (MSM-IDU)	• 84% of HIV/AIDS cases • 88% of new infections • Community viral load (CVL): 36,261 copies/mL for MSM-IDU, compared with citywide mean of 23,348	Unprotected anal sex, substance use, multiple partners, sexually transmitted diseases (STDs), mental health, discrimination and stigma, high-risk/high-prevalence sexual networks, use of internet to meet sexual partners
MSM substance users	• SF MSM using alcohol (heavy use), crack/cocaine, meth, and/or poppers are between 2 and 3 times more likely to seroconvert, based on multiple studies	Unprotected anal sex, discrimination and stigma, mental health, isolation/lack of sense of community
African American MSM	• 9% of all MSM HIV/AIDS cases*	Unprotected anal sex, discrimination and stigma, homophobia, racism, substance use, poverty and homelessness, sex-drug exchange, lack of knowledge/information about HIV, STDs, incarceration
Latino MSM	• 15% of MSM HIV/AIDS cases*	Unprotected anal sex, discrimination and stigma, cultural context (e.g., norms around sexual silence), substance use, mental health
Injection drug users (non-MSM)	• 4% of HIV/AIDS cases • 7% of new infections • CVL: 33,245 copies/mL for MSM-IDU, compared with citywide mean of 23,348	Unprotected sex, poverty, sex work, homelessness, incarceration, mental health, sexual networks (sexual partners who are also injecting partners)
Transfemales who have sex with males	• 2% of HIV/AIDS cases • 2% of new infections • CVL: 64,160 copies/mL for MSM-IDU, compared with citywide mean of 23,348	Unprotected sex, poverty, substance use, discrimination and stigma, sex work, mental health
HIV-positive people unaware of their status	• 15% of PLWHA are unaware of their infection • This group likely has some of the highest viral loads because they are not in care/on treatment	Late testing/no testing due to fear, lack of awareness of risk, lack of awareness of improved HIV treatment, not knowing that free/low cost care is available, substance use
HIV-positive people not on treatment/not engaged in care	• 18% of PLWHA who are aware of their status have an unmet need for HIV primary care in the prior 12 months • PLWHA not on treatment/not engaged in care have higher mean CVL compared with PLWHA citywide (40,056/36,992 vs. 23,348)	Treatment non-adherence and missing appointments due to mental health, substance use, unstable housing, discrimination and stigma, low literacy, cognitive impairment, and other issues

*Incidence data for MSM not available by race/ethnicity.

4. <u>Current HIV prevention situation, including gaps.</u> SF has been a leader in HIV prevention from the early days of the epidemic. Over the past 30 years, dozens of community organizations have provided HIV prevention services to San Franciscans, and a robust Department of Public Health (DPH) has supported these efforts while setting trailblazing policies and developing innovative, effective program models. Today, the biggest need is for coordination of these services into one seamless **Continuum of Prevention, Care, and Treatment** for people living with and at risk for HIV (referred to as "the Continuum" from here on). Exhibit 4 shows how the Continuum, when fully implemented and coordinated, will **reduce new HIV infections.**

Exhibit 4: SF Continuum of HIV Prevention, Care, and Treatment: A Logic Model



Despite evidence-based HIV prevention programming and cutting edge care and treatment services, substantial gaps and unmet need exist across this continuum (Exhibit 5), including those who are living with HIV but unaware of their infection and those whose HIV infection is known but who have unsuppressed viral load.

Sexual risk behavior prevention need	HIV testing need	Linkage to care need, community setting	Retention in care need	Viral suppression need
17% Among MSM, unprotected anal sex with serodiscordant or unknown status partner, during the last 6 mos.[7]	**55%** % of MSM, IDU, and transfemales who have not tested for HIV in prior 6 mos. [6,7]	**36%** % of CBO clients who test HIV+ and are not linked to medical care in 3 months [HPS program data]	**24%** % of all HIV+ with unmet need (defined as not having at least one CD4 or viral load or not taking antiretroviral therapy during the last 12 mos.) [2]	**67%** % all HIV+ people with detectable virus [2]

These gaps can be categorized into four major areas as follows:

Testing gap. 15-20% of people living with HIV/AIDS (PLWHA) in SF are unaware of their infection. If all MSM, IDU, and TFSM were to test every 6 months, 70,000 more tests will need to be done citywide.[6,7] In addition, PLWHA with long-standing undiagnosed HIV infections who do not identify with traditional risk groups or who have other testing barriers are not being fully reached.

PLWHA not on treatment/not engaged in care. In SF, among people with known HIV infection, 28% have unsuppressed viral load [4], and 24% are not engaged in HIV primary medical care (Exhibit 4). Current retention/re-engagement efforts are substantial, but they are insufficient to meet the need and they lack coordination.

HIV-related disparities. In SF, gay men, African American MSM, and TFSM experience the greatest HIV-related disparities.[2] Gay men represent the vast majority of HIV/AIDS cases and new infections, 87% and 88%, respectively.[1, 2] African American MSM are over-represented among HIV/AIDS cases compared with their numbers in the population (African Americans in general represent 6% of the SF population, but make up 14% of people living with HIV/AIDS).[2] TFSM have extremely high mean community viral load: 64,160 copies/mL, which is three times the city average.[4]

Coordination across the Continuum. In an era when resources are dwindling and the slogan "Prevention = Care and Care = Prevention" is now a very real and meaningful concept, SF needs to work smarter, not harder. This means coordinating efforts to reduce service duplication and prevent gaps in service, leveraging resources, and aligning cross-disciplinary efforts in pursuit of common goals and objectives. Within and outside of the health department, coordination and collaboration will be needed at all levels and among multiple stakeholders in order to realize this vision. Experts in a wide range of topics and functions—including but not limited to primary care, substance use, mental health, housing, STDs, hepatitis, tuberculosis, the gay/bisexual/transgender community, data systems, data security and confidentiality, health care reform, and service integration—will need to be brought to the table.

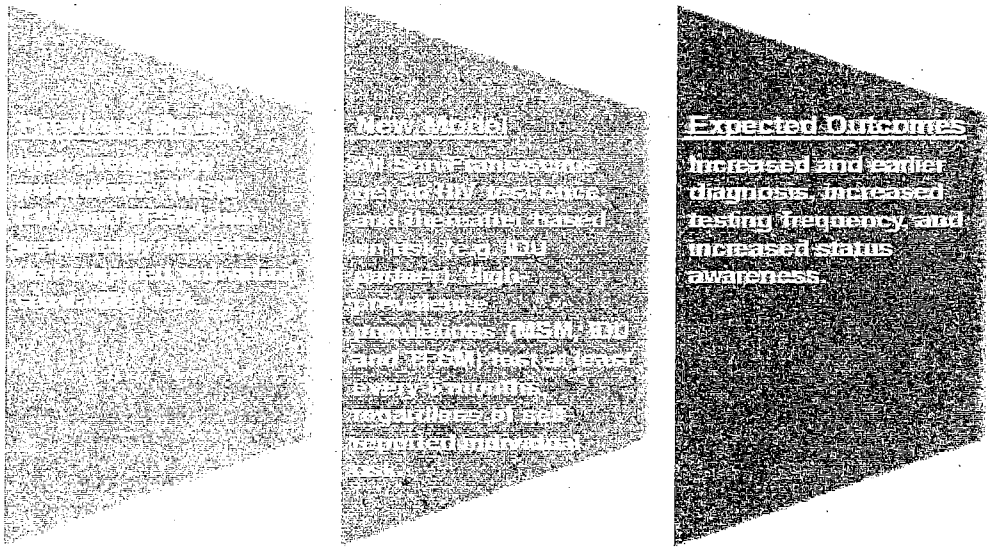
5. <u>Experience, expertise, and existing capacity to provide services.</u> The staff members in charge of HIV prevention in all three counties in the Metropolitan Division have a wealth of experience and expertise in the delivery of HIV prevention services. The SF Bay Area and the City of SF in particular are national leaders in the fight against HIV. Although the content expertise is substantial, capacity-building needs remain in order to work more efficiently and effectively. SF has identified 4 major areas related to coordination and collaboration that currently hinder HIV prevention efforts, and set goals to improve existing capacity in these areas (Exhibit 6).

Exhibit 6. Addressing SF's Capacity-Building Needs			
Goal	**Assets and Current Capacity**	**Gaps & Capacity-Building Needs**	**Strategies to Address Capacity-Building Needs**
Improve coordination of data systems	• Use of surveillance data for measuring linkage, retention, engagement, and CVL • Program Collaboration and Service Integration (PCSI) assessment • Routine HIV surveillance	• A coordinated names-based citywide service utilization data system	• Secure funds for the development, implementation, and evaluation of an integrated names-based data system (see Category C1 application)
Expand and adapt	• ECHPP and PCSI Steering Committees	• Collaborations with partners with a broad range of expertise	• Conduct provider trainings • Allocate staff time to build

partnerships and collaborations	• Collaboration with DPH Primary Care Quality Improvement Committee • HPPC and CARE Council • New provider partnerships for Prevention with Positives (PwP)	to develop provider trainings on prevention with positives (PwP), evidence-based treatment adherence models, new developments in HIV (e.g., PrEP), and more • More community engagement	relationships
"De-silo" funding streams to promote integrated service models	• Collaborative planning for NHAS-related grant applications • Joint HIV Health Services/HPS funding of PwP • Oversight of SAMHSA HIV dollars through HPS • Recommendations from PCSI Steering Committee	• Leadership positions within SFDPH to promote structural changes	• Establish HPS Strategic Integration Unit to work across DPH sections to promote integrated services
Realign, maximize, and leverage existing resources to increase impact	• Recent HPS RFP process scaled up testing, refocused PwP, scaled down sexual risk reduction interventions • Promotion of third party billing for HIV testing in medical settings • SF program (Healthy SF) covers care for un- and under-insured	• HIV budget planning and management across SFDPH • Direct revenue generated from increased 3rd party billing of HIV testing to supported increased laboratory costs	• Establish HPS Operations Unit in charge of identifying opportunities to leverage HIV funds citywide, in collaboration with Strategic Integration Unit

B. Program Description

Required Intervention #1. HIV Testing.



To meet the demands inherent in the new local model for testing, SF is currently in the process of dramatically scaling up HIV testing programs throughout the city, both in volume of tests and in the diversity of venues in which testing will be offered. SF plans to address the current testing

gap among those at highest risk for HIV infection, and ensure that as many HIV-positive San Franciscans as possible are aware of their HIV status and engaged in care. The following pages describe these efforts in detail.

a) Opt-out testing of patients ages 13-64 in healthcare settings. The goal of the SF routine testing efforts is to establish a structural change within SF's clinical systems such that HIV screening becomes a routine part of clinical care, similar to cholesterol checks. Routine opt-out testing will be conducted in at least 31 health care facilities in the following settings: SFDPH Primary Care Clinics, SF General Hospital (SFGH), Jail Health Services, and the SF Community Consortium (SFCCC) (memoranda of agreement provided in Attachment 3). These healthcare facilities were chosen because they include patients who would not self-identify as being at-risk for HIV and therefore are unlikely to request or seek out HIV testing. Such patients are not likely to have recently received a test, as documented by both SFGH clinical data [8] and a 2009 SFDPH-supported evaluation conducted by the UCSF Center for AIDS Prevention Studies (CAPS) with the support of the SFDPH.[9] These data reinforce that these

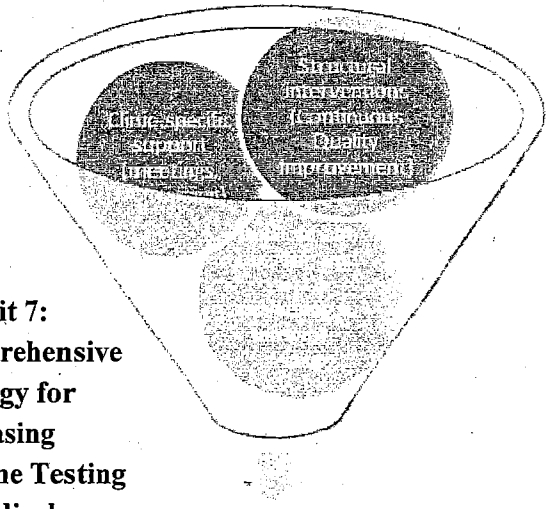


Exhibit 7: Comprehensive Strategy for Increasing Routine Testing in Medical Settings

locations are ideal for diagnosing long-standing unknown HIV infections. Since 2006, the SFDPH has worked with public health medical settings to increase routine testing, including successful efforts at the SFGH Emergency Department, the county jails, and one of the major SFDPH-run primary care clinics in the city (Tom Waddell Health Center). However, routine HIV screening is still not the standard of care at all health care settings in SF, as is the ultimate goal. Therefore, over the next five years SF will be implementing or enhancing a number of interventions toward this end. Our comprehensive strategy is highlighted in Exhibit 7 on the previous page and described in greater detail in the Category B narrative.

Exhibit 7 depicts the specific planned interventions, which include: (1) **clinic-specific training and technical assistance** to promote collaboration and input among clinicians and support staff for this new approach, and to identify and address barriers faced by specific clinics to implementing the guidelines; (2) **development of continuous quality improvement (CQI) guidelines** to ensure that routine HIV testing becomes standard of care throughout DPH and eventually in non-DPH medical settings; and (3) **public health detailing and social marketing** to encourage clinicians to offer testing and patients to ask for testing.

By bringing these additional HIV testing programs in medical settings under the umbrella of services supported by HPS, the SFDPH is better able to ensure that testing is conducted using the "new model" approach described above. Furthermore, it will ensure that any person testing HIV-positive in these locations has excellent support in linking to high-quality HIV medical care and partner services, and that the support is culturally and linguistically appropriate and delivered in a manner consistent with applicable CDC guidelines and recommendations. In addition, HPS will have more oversight with regard to the following: HIV testing among

pregnant women, using the best available test technologies and testing strategies to maximize the number of people who receive their test results, and laboratory quality assurance.

In these healthcare settings, consent will be opt-out and no separate written consent will be required, per California law (AB682), which governs consent for HIV testing in medical settings. The law requires the provider to provide information to the patient about HIV and the test, including the patient's right to decline the test. If a patient declines, the provider must note it in the patient's medical file.

b) HIV testing in non-healthcare settings. In addition to the testing in medical settings, SF will support targeted testing in community settings through two types of projects: (1) citywide HIV testing programs targeting MSM, IDU, and TFSM (services to be provided by three sites: the San Francisco AIDS Foundation (SFAF), UCSF AIDS Health Project, and SFDPH City Clinic—SF's municipal STD clinic); and (2) holistic health programs addressing populations with the greatest disparities—African American MSM, Latino MSM, MSM regardless of race/ethnicity, and TFSM (services to be provided by AGUILAS, Asian & Pacific Islander Wellness Center, Instituto Familiar de la Raza, SFAF, and Tenderloin Health). These programs will include testing at sites such as organization offices, community-based clinic locations, mobile vans, syringe access services centers, in venues frequented by the target populations (i.e., bars, clubs, sex clubs), and through street outreach.

SF agencies to provide targeted HIV testing in community settings were selected in the spring of 2011 through a competitive process (referred to as the "2010 RFP process"), following the release of the 2010 SF HIV Prevention Plan developed by the HIV Prevention Planning Council (SF's CDC-mandated HIV prevention community planning group).[6] Proposals were scored based on the applicants' success in documenting their ability to provide high-quality,

high-volume services to people at highest risk for HIV, in neighborhoods of the city with high HIV incidence and prevalence, in a high-impact and cost-effective way. Funded applicants used sources such as the SF HIV Epidemiology Annual Report [2] and their own historical program data to justify their proposed programs. They were also scored based on their demonstration of how they would provide all client services in a culturally and linguistically appropriate manner. Funded agencies must use the SFDPH Public Health Laboratory for all off-site testing in order to guarantee lab quality, and are required to deliver all services according to CDC guidelines and recommendations. Finally, as a condition of funding they agree to participate in whichever testing technologies or testing algorithms the SFDPH determines are best for use in their setting.

In community-based settings, written consent will still be obtained. All testing at these sites will be opt-in, as the testing in these sites is designed to be for individuals who seek out testing services. Part of the consent process in these sites includes a discussion of the city/county procedures for HIV testing, the reporting requirements, and the linkage services that will be provided should they test positive.

c) Support HIV testing activities to reach persons with undiagnosed HIV infection. In SF, 15-20% of PLWHA (n=2,740 – 3,715) are unaware of their status.[1] The majority of undiagnosed infections are distributed among the three high-prevalence populations of MSM, IDU, and TFSM, and sporadically among heterosexual men and women who may have acquired HIV without being aware of their risk or exposure.

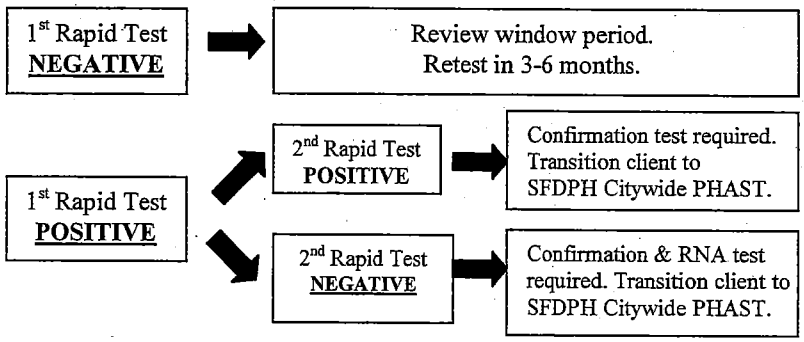
Community-based testing will target the three high-prevalence populations (but no one seeking an HIV test will be turned away). This strategy will reach persons with undiagnosed HIV infection by rapidly scaling up and expanding testing frequency—tripling the annual number of tests from approximately 10,000 currently to 30,000. The selected agencies described above have

a strong track record of reaching these populations through on-site testing, mobile and venue-based testing in highly impacted neighborhoods, such as the Castro, Bayview/Hunter's Point, Mission, SOMA, and Tenderloin. Collectively, in 2010 these agencies had a positivity rate of 1.5%, diagnosed 170 new HIV infections, and identified 13 acute infections through strategic implementation of RNA testing.

Routine opt-out testing in the selected DPH medical settings will also identify new infections among MSM, IDU, and TFSM, especially among (1) populations of color who would not actively seek a test in a community-based setting due to fear or stigma, and (2) populations who experience other barriers to seeking HIV testing (e.g., substance use, mental health). Routine testing will also diagnose sporadic cases in low-prevalence populations. For instance, data from the SFGH Emergency Department (ED) has demonstrated that routine opt-out testing can reach this group of individuals who do not identify as MSM, IDU, or TFSM and still yield a high new positivity rate of 1.26%.[8]

d) Ensure the provision of test results. For cases diagnosed in healthcare settings, HPS's new Clinical Prevention Unit will track all new HIV cases using data from SFDPH's electronic medical record and HIV surveillance data and conduct follow-up with the ordering clinician to ensure that s/he discloses HIV-positive results to patients. In the SFGH Emergency Department, although rapid point-of-care testing

Exhibit 8: SF Rapid HIV Testing Algorithm



involves running the rapid test in the hospital laboratory, there is only a 1 to 2-hour turnaround time so that patients can receive their results before they are discharged.

All testing in community-based settings is rapid testing, which ensures that both HIV-positive and HIV-negative results are disclosed at the same appointment. At these sites, a two-test algorithm is used, as described in Exhibit 8 on the previous page. Clients with preliminary HIV-positive results are told, "We believe you have HIV," and are linked to care and offered partner services while awaiting a confirmatory result/RNA test. These clients will be notified only if their follow up tests indicate the absence of HIV infection. All HIV-positive disclosures will be done in-person, in private sessions with trained staff or volunteers.

Rather than requiring that confirmatory test results be provided to clients by the site providing the initial rapid test, California state regulations require that all people who receive a reactive screening test result are provided with the results of confirmatory testing whenever possible. SF has worked with the California State Office of AIDS to develop a system whereby people who test positive with a rapid HIV test are provided with prevention counseling, then immediately linked to the new SFDPH Citywide Positive Health Access to Services and Treatment (PHAST) program (to be described in detail in the *Comprehensive PwP* section of this application). All people who test positive for HIV in SF, regardless of their testing location, will be linked to the Citywide PHAST program. Citywide PHAST program staff will initiate partner services (PS), and ensure that HIV-positive individuals are linked as soon as possible to HIV medical care that will include confirmatory antibody testing. Following this procedure not only helps to strengthen the linkage of newly diagnosed individuals to HIV medical care as quickly as possible, but eliminates the previous, costly redundancy where community sites routinely ran

confirmatory testing and then medical care sites also ran the same tests to confirm infection before providing care.

e) Promote routine, early HIV testing for all pregnant women. SF is home to the Bay Area Perinatal AIDS Center (BAPAC), which seeks to eliminate perinatal HIV transmission through three interventions: (1) the provision of comprehensive preconception and prenatal care to HIV-infected women and high-risk HIV-uninfected women; (2) optimization of routine prenatal HIV testing; and (3) educational outreach to the community and medical providers in the Bay Area and nationwide. In addition to launching rapid HIV testing on Labor and Delivery wards at both SFGH and UCSF Medical Center, BAPAC staff have helped launch the California-wide, CDC-sponsored Rapid HIV Testing on Labor and Delivery Project to assist hospitals with implementation of rapid HIV testing in California labor and delivery facilities. In addition to strongly promoting rapid HIV testing for all women with unknown HIV status in any labor and delivery facility in the Metropolitan Division, SF follows the CDC's 2006 *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Healthcare Settings* [10] and has set citywide standards to encourage HIV testing for all pregnant women enrolled in prenatal care in the city. BAPAC staff have led the charge to optimize universal, opt-out HIV testing in the outpatient prenatal setting at SFGH—increasing prenatal HIV testing uptake from 29% in 2003 to 97-100% in 2006 with the transition from HIV test counselors to integrated nurse-initiated counseling and testing.[11] This high testing uptake among pregnant women has been sustained at SFGH with the standardization of nurse-initiated testing. BAPAC offers technical assistance to support these efforts for obstetrics clinics throughout the city as needed, and regularly works on a number of research and educational fronts to further optimize routine prenatal HIV testing in SF and beyond.

f) Increasing the number of persons diagnosed with HIV through strengthening current HIV testing efforts or creating new services. HPS aims to create a norm in which HIV testing at least every 6 months becomes the standard of care among high-prevalence populations, and all other populations are tested in accordance with the "new model" described earlier. HPS will strengthen current efforts by: (1) further expanding routine testing in medical settings (see section 1a), and (2) substantially increasing the volume of testing provided in community-based settings targeting MSM, TFSM, and IDU (see section 1b). HPS will also implement the following new efforts: (1) working across SFDPH to integrate routine opt-out HIV testing into DPH CQI guidelines; (2) implementing a social marketing campaign to encourage patients/clients to ask for testing and clinicians to offer testing routinely; and (3) working with health and social service providers who do not provide HIV testing to link them to agencies that can provide testing, either on-site or through referral and direct linkage.

g) Facilitate voluntary testing for other STDs, HBV, HCV, and TB in conjunction with HIV testing. A Program Collaboration and Service Integration (PCSI) Steering Committee, composed of SFDPH programmatic and surveillance staff representing HIV, STDs, hepatitis B and C, and TB, has completed an assessment of "syndemics" in SF focusing on these diseases. The assessment revealed patterns among the four diseases and identified populations most affected by two or more. For example, the highest HIV co-infection rates were with hepatitis B and C, latent TB, and Chlamydia, and those likely to be co-infected with HIV and another disease were more likely to be non-white, middle-aged, IDU, or MSM-IDU. Based on these findings, the Committee is currently developing clinical guidelines for integrated screening activities, to be implemented in DPH medical settings. The Committee is also exploring the

functional integration of surveillance data for these diseases in order to facilitate better targeted screening and patient care and follow-up.

In addition, HPS will: (1) work with community-based HIV testing providers to leverage resources in order to provide integrated screening services where relevant (e.g., STD/HIV/HCV testing at sites serving gay men), and (2) develop referral lists and linkage protocols for all HPS-funded programs so that clients can access voluntary testing for HIV, STDs, viral hepatitis, and TB at other sites.

h) Ensure quality of testing laboratories. All conventional (non-rapid) HIV testing in SF is processed through one of two SFDPH laboratories (the city Public Health Laboratory and SFGH's Clinical Laboratory) or a private laboratory such as Quest or LabCorp. Rapid point-of-care HIV testing conducted in the SFGH ED is processed in the SFGH lab. SFDPH regularly reviews the testing laboratories for any HIV testing providers citywide, to ensure that the laboratory they are using adheres to adequate quality standards. The two SFDPH laboratories follow CDC and Association of Public Health Laboratory (APHL) guidelines for HIV testing algorithms, report findings of results to providers within a maximum of 10 days (often with a much shorter turnaround), and participate in at least one laboratory performance evaluation program for HIV testing. If SFDPH became aware of any failure to adhere to these standards, immediate notification would be provided to all HIV testing sites throughout the city to recommend they suspend use of that testing laboratory until the situation is rectified.

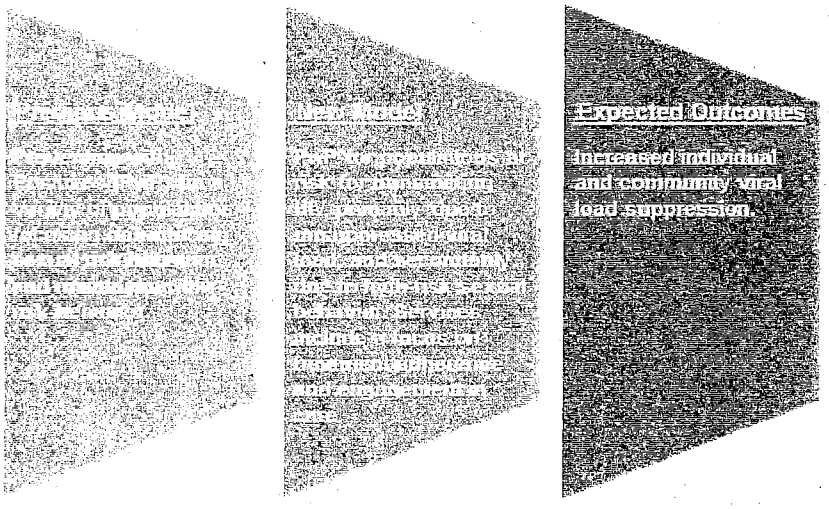
i) Incorporate new testing technologies. SF has been a leader in utilizing new HIV testing technologies (see Exhibit 9).

Technology	SF Leadership
Rapid HIV testing	In 2003, Glide Health Services in SF became one of the first places in the country to pilot the rapid HIV test.
Pooled RNA testing	In 2005, SF City Clinic began pooled RNA testing to identify acute HIV infections.

Rapid point-of-care test algorithm	In 2006, CDC selected the SFDPH as one of two places in the nation to implement a feasibility study of a multiple-test rapid point-of-care algorithm to determine whether a rapid algorithm was a suitable method for determining HIV status in one day, rather than waiting for a confirmation test result. This 2-test algorithm is now used at HPS's community-based testing sites (see Exhibit 8, p. 12).
4th generation testing	In 2011, all first-pass HIV antibody testing performed through the SFDPH laboratory will use the 4th generation test. The CDC-sponsored STOP Study will compare the yield of 4th generation testing to pooled RNA testing of samples from selected high-prevalence sites.

Through this history of innovation, SF has clearly demonstrated an ability to incorporate new testing technologies whenever feasible and appropriate. Furthermore, the presence of cutting-edge diagnostics researchers at UCSF means that testing sites in SF are frequently able to participate in efforts to use innovative testing technologies through research opportunities funded by CDC, NIH, and others. Finally, SF and San Mateo County are collaborators in an "I Want the Kit" project, promoting home-based testing for STDs. The SF Division will explore the feasibility and effectiveness of promoting increased use of home-based HIV testing.

Required Intervention #2. Comprehensive Prevention with Positives (PwP).



SF has been providing prevention services especially designed for HIV-positive individuals since 2004, and referral and linkage services for people testing newly HIV-positive have been an important part of SF's testing programs since their inception. In this new era of

HIV prevention, SF is putting renewed emphasis on a comprehensive program that emphasizes prevention with HIV-positive people at risk for transmission, which includes those acutely infected and those with unsuppressed viral load. Surveillance data in SF has highlighted a substantial unmet need for our HIV-positive residents: 28% of HIV-positive people in SF have unsuppressed viral load,[4] and 36% of clients who test HIV-positive at community testing sites cannot be confirmed as linked to medical care [HPS program data]. Finally, although partner services has been proven an extremely effective HIV prevention intervention, it is highly underutilized in SF.

Mindful of these unmet needs in mind, SF has developed a comprehensive PwP program consisting of three main categories of service: (1) community-based PwP, (2) PwP within Centers of Excellence (Ryan White-funded one-stop shops for PLWHA), and (3) the new Citywide PHAST Team, which aims to ensure linkage to care within 30 days for everyone testing positive within SF, that all newly-diagnosed people are offered comprehensive linkage and partner services, and that no one falls out of care, or if they do, that they are re-engaged with care as quickly as possible. Details are included in the following pages. By establishing a comprehensive, citywide PwP program, the SFDPH is better able to ensure that all providers in this system are delivering services in a manner consistent with applicable CDC, state, and local guidelines and recommendations, and that all services are provided in a culturally and linguistically appropriate manner. If deficiencies are found in either of these areas, HPS staff will immediately provide technical assistance to make changes in service provision as needed.

a) Linkage to HIV care, treatment, and prevention services.[1] SF's main strategy for providing high-quality and timely linkage services to people newly testing HIV-positive or

[1] Memoranda of agreement with referral agencies are in progress and will be provided at a later date.

currently living with HIV/AIDS is the new SFDPH Citywide PHAST program, which is modeled on a highly effective linkage/retention program still in operation at SFGH. A key element of the SFGH program's success is the personalized service clients receive, and the Citywide PHAST Team will employ a similar approach. To reduce the need for clients to interface with multiple people and systems upon diagnosis and throughout the course of their care, Citywide PHAST will incorporate initial linkage to HIV medical care, social services, partner services, and retention in care services all under the umbrella of this one program. Services will be tailored to individual clients and range from intensive case management to assistance with scheduling an initial care appointment.

The specialists providing initial linkage to care on the Citywide PHAST Team are also partner services and social services specialists, because in order to be client-centered and resource-efficient, newly diagnosed people will have a single skilled and knowledgeable individual coordinating their transition to care and addressing any needs that arise. Citywide PHAST linkage staff will be available to serve clients testing HIV-positive at community-based sites in the following two ways: (1) a staff person will work on-site at each of the two high-volume citywide testing sites—SFAF's Magnet clinic and AIDS Health Project, and (2) two "rovers" will serve the lower-volume community-based testing sites as well as medical sites and will be available by cell phone. These staff will provide comprehensive linkage services, including linkage to primary medical care and prevention services, as well as partner services (discussed later in section (d)), to anyone testing HIV-positive at either of these community-based testing sites. All linkage activities and outcomes will be systematically tracked by Citywide PHAST staff in a database that will be fully functional by program launch.

b) Promote retention or re-engagement in care. SF is rich with opportunities for high-quality medical care for HIV, and multiple interventions funded by various sources currently exist to support engagement to care for people with HIV. However, these efforts are not coordinated, resulting in people "falling through the cracks" (see Exhibit 4 for unmet needs along the Continuum). The Citywide PHAST Team will serve as a "safety net" to catch these people by: (1) identifying people with unmet needs (e.g., unsuppressed viral load, not in care) via use of HIV surveillance data and referral from medical providers; (2) providing navigation services to re-engage these individuals in care; and (3) coordinating across existing re-engagement services throughout SF using case conferencing and other mechanisms to ensure that all clients are being provided with the appropriate type and intensity of service.

The three functions described above will be performed by "navigators," who are members of the Citywide PHAST Team. Multiple skill sets will be represented on the navigators team. First, the team will have expertise in the various data systems that are used by HIV testing, HIV prevention, social service, and medical providers throughout SF, and will analyze the data within those systems on a client level to identify people who were not linked or do not appear to be currently engaged in care. They then use their relationships with medical sites and providers to ensure that these people are linked or re-engaged as quickly as possible. The team will also have the capacity to provide direct services to clients, supporting them to navigate into and through the system of care, providing counseling to address barriers to engaging in care, and offering treatment adherence support, or whatever else the client needs to fully engage in their care.

The navigators will not only focus on the needs and health of individual clients, but will also take a systems approach to monitoring and improving health outcomes for people with HIV

citywide. Specifically, this team will also be responsible for promoting the strategic use of surveillance and other clinical data to track health indicators for HIV-positive people in SF, such as community viral load. This data will then be used to engage directly with DPH CQI staff to improve care systems.[2]

c) Referral and linkage to other medical and social services. In addition to the referral and linkage services offered by Citywide PHAST, there are three other main ways that HIV-positive San Franciscans are linked to the medical and social services that they need. The first is through the two community-based PwP programs funded under the most recent RFP process, provided by STOP AIDS Project and Tenderloin Health. These agencies and their collaborators provide an extensive array of health and social services for people with HIV, including substance use treatment, mental health services, housing services, and benefits counseling. For services they do not provide in house, these agencies have strong referral relationships with many other service providers in SF to be sure that the needs of their clients are met.

Second, in 2010 SF issued an RFP to support six "Centers of Excellence" (CoEs), designed to be "one stop shops" for HIV primary care and wraparound services, focused on specific populations of need. The four following Centers of Excellence include funding dedicated to PwP: (1) African American CoE, (2) Mission CoE (serving Latinos), (3) Tenderloin Area CoE (one of the highest HIV prevalence and lowest income neighborhoods in SF), and (4) CCHAMP CoE (Chronic Care HIV/AIDS Multi-Disciplinary Program, serving individuals with advanced medical needs and/or who are multiply-diagnosed). Each of these Centers are exceptionally suited to provide comprehensive medical and social services support for their target population.

[2] SF's Category C application, "Augmenting High-Impact Prevention (A-HIP)" will greatly enhance SF's capacity for this public health CQI approach.

Third, all HPS-funded HIV prevention providers are required to link or refer clients to Healthy SF, SF's health program for the un- and under-insured, or other appropriate health coverage, in keeping with SFDPH's goal that every resident have a primary care home.

d) Provide ongoing partner services. SF City Clinic, the municipal STD clinic, will oversee the HIV partner services and linkage staff that are part of the Citywide PHAST Team due to their extensive capacity and experience with HIV and STD partner services. City Clinic has been providing partner services in their own clinic since 2004, and to SFGH patients and people co-infected with HIV and syphilis since 2005.[12] These Citywide PHAST staff will directly offer HIV partner services to every individual who tests positive at any site in SF (community-based or medical), at the same time they are providing linkage to primary care and social services. They are able to do this because of their strong collaborations with the HIV Epidemiology Unit, which maintains SF's HIV surveillance data and notifies the Citywide PHAST Team within 72 hours that a newly reported case is confirmed as a new diagnosis, and SF's Public Health Lab, which will alert the Citywide PHAST Team whenever there is a positive test. This "direct offer" approach will help with uptake of partner services, because referrals to partner services by community-based and medical test sites have been minimal due to it being a low priority for sites. These staff will also offer partner services to people with long-standing HIV infection, including Citywide PHAST navigation clients and individuals referred from community-based PwP programs. This expansion of partner services beyond the newly diagnosed is a longer term priority, for years 2 and beyond.

The primary outcome to measure the success of the service is the number of new HIV diagnoses it generates by testing partners. Additional outcomes include number of partners elicited per index case, number contacted, number tested, and cost.

e) Interventions with HIV-positive pregnant women to prevent perinatal transmission. Part of the UCSF Positive Health Program at SFGH, the previously described BAPAC has been remarkably successful at preventing perinatal HIV transmission in SF. There has only been a single case of perinatal transmission among women engaged in care at BAPAC since the antiretroviral therapy (ART) era began in 1996. This sole case in 2004 involved a woman with pan-resistant HIV at the onset of pregnancy.

Medical care for pregnant women through BAPAC involves the initiation and monitoring of ART, intensive adherence counseling and support, comprehensive prenatal care including genetic counseling, ultrasound, and nutritional counseling, as well as extensive education on the prevention of sexual and perinatal HIV transmission and contraception. BAPAC also offers preconception care and intensive partners counseling. The BAPAC Ob-Gyn also provides 24 hour a day backup services on the Labor and Delivery ward at SFGH.

BAPAC serves clients not just in SF but throughout the entire Bay Area, including San Mateo and Marin counties. Pregnant women still receive prenatal care in their county of residence, in coordination with BAPAC (or Stanford University), but the delivery occurs through BAPAC or Stanford, who are the experts.

f) Sentinel event case review of missed perinatal HIV prevention opportunities. SF participates in the CDC-funded Pediatric Spectrum of Disease sentinel surveillance project, which monitors infants born to infected mothers throughout Northern California. This project would identify any new pediatric cases that might represent missed opportunities for HIV screening/prevention. The SFDPH would then conduct a case review to see if any systems-level issues or protocols need to be addressed. However, this process has not yet been used as there have been no pediatric (less than 13 years old) HIV cases diagnosed in SF since 2004.

g) Behavioral and clinical risk screening and risk reduction interventions. SF's CoEs, as explained in section 2c above, are designed specifically to enhance behavioral and clinical risk screening for Ryan White-eligible HIV-positive people in SF and make referrals to risk reduction interventions when appropriate. All CoE clients receive an intake assessment, where they are screened for behavioral and clinical risk, and are referred to the CoE's PwP risk reduction interventions when indicated.

In addition, many un- and under-insured HIV-positive clients not eligible for Ryan White services receive primary care at one of SFDPH's Community-Oriented Primary Care clinics. The clinics have recently adopted the "behaviorist model" of service for their patients, in which each clinic has a staff behaviorist who is available for ongoing counseling, support, and referrals for primary care patients with more complex needs that rise above their medical provider's general purview. Clinicians refer patients with risk reduction needs to the behaviorist, who is trained to provide advanced behavioral and clinical risk intervention.

All HIV-positive patients including those receiving care from private facilities who would benefit from community-based adherence support will referred to the STOP AIDS Project's PwP program. This program will provide not only treatment adherence interventions, but also behavioral risk screening and risk reduction interventions. These interventions are described in more detail in the next section (h). STOP AIDS is funded specifically to build relationships with private medical providers, in order to encourage regular behavioral and clinical risk screening leading to referral to STOP AIDS risk reduction interventions when indicated.

h) Implementation of behavioral, structural, and/or biomedical interventions. All three PwP components—community-based PwP, PwP in CoEs, and the Citywide PHAST Team—will provide behavioral and biomedical interventions, including treatment adherence. The Citywide

PHAST Team itself represents a structural intervention, by using data in novel ways to promote individual and population-level health outcomes. Because the latter two components have already been thoroughly described, this section will focus on the two community-based PwP programs.

First, STOP AIDS Project runs a multi-intervention PwP program called Positive Force, which includes adherence support services and wellness support services for people with HIV in their program. Adherence support services offered through Positive Force include a weekend-long seminar designed to provide education, support and community building for people who are newly diagnosed or newly dealing with their HIV status, as well as medical adherence groups co-facilitated by a physician and a STOP AIDS Adherence Specialist. Wellness support services include treatment adherence educational events, social support events including social gatherings, and support of a social networking website for HIV-positive MSM called Positive Force Online. Clients are recruited from community-based clinics and private HIV specialists, through treatment adherence educational events, and through other community-based organizations (CBOs) that offer HIV prevention services. STOP AIDS expects to provide PwP services to approximately 350 clients per year, with over 3,000 total yearly client contacts.

Second, Tenderloin Health will provide comprehensive risk counseling services (CRCS), a peer support program that utilizes trained peer volunteers to act as role models on treatment adherence and risk reduction behaviors, multiple-session workshops tailored to particular target populations in order to provide health education and information as well as to foster community engagement on barriers to HIV-prevention among HIV-positive people, community forums designed to bring together larger groups of HIV-positive people along with their friends, family, and partners in order to discuss issues impacting their HIV transmission risk, and the *d-up:*

Defend Yourself DEBI to change social norms and perceptions of Black MSM regarding condom use. Tenderloin Health expects to provide these services to approximately 550 clients per year, with over 3,000 total yearly client contacts.

Both agencies offering these interventions are doing so under contract with HPS, which require that services are provided in accordance with DPH's Culturally and Linguistically Appropriate Services (CLAS) Standards, in a manner consistent with applicable CDC and/or state/local guidelines and recommendations. HPS provides ongoing oversight, and agencies undergo annual formal, written monitoring to evaluate performance. Continued funding is contingent on satisfactory provision of services.

i) Support integrated hepatitis, TB, and STD screening and partner services. The SF PCSI working group, as discussed earlier, is focusing on the development and implementation of clinical guidelines for integrated screening activities. The SFDPH is currently in the process of exploring the integration of surveillance data for these diseases in order to facilitate better targeted screening, patient care, and follow-up. Lastly, all HPS-funded agencies are required to either offer screening for these diseases or have formal systems to provide linkage for their clients to clinics that provide such screening.

Syphilis and HIV partner services are already integrated, based on data showing the high co-infection rates, and provided in tandem by SF City Clinic to all HIV-positive clients newly diagnosed with syphilis. All SF City Clinic clients newly diagnosed with HIV are offered STD testing. Finally, a few community-based sites, such as SFAF's Magnet, offer integrated STD/HIV testing.

j) Reporting and use of CD4 and viral load results. All SF providers are required to report CD4 and viral load results to the HIV Epidemiology Section of the SFDPH, which is

responsible for HIV surveillance. These results are reported both by the ordering clinician and the laboratory that ran the test. Each of the major testing laboratories in SF has automated systems for reporting these results as required, ensuring high completeness levels for reporting. This requirement for dual reporting helps ensure that no CD4 or viral load tests go unreported. HIV surveillance data including CD4 and viral load results are regularly used through collaboration between HPS and HIV surveillance staff to target and evaluate linkage and retention in care (as described in the earlier section about the Citywide PHAST Team), assess quality of care by various clinicians, and provide feedback of results to providers and patients if deemed appropriate and within confidentiality regulations. In addition, HPS and the HIV Epidemiology Section collaborate to track CVL for SF overall, as well as specific subpopulations (e.g., by neighborhood, race, gender). Two types of CVL are monitored—total CVL, which is a measure of viral burden, and mean CVL, which is a measure of health disparities. These data are then fed back and used to improve quality and targeting of services.

k) Provision of ART in accordance with current treatment guidelines. In April 2010, after reviewing scientific data with regard to the benefits and risks of initiating earlier treatment, SF health officials announced a policy change to recommend offering ART to all people diagnosed with HIV regardless of CD4 count, with a commitment to providing care and medications regardless of insurance coverage or an individual's ability to pay. As far as SFDPH is aware, this is the first policy in the nation to recommend a universal offer of treatment for persons infected with HIV. The policy applies to all SFDPH medical facilities, and is encouraged for all SF medical providers regardless of affiliation. HPS's new Clinical Prevention Unit will promote uptake of the local ART guidelines through a citywide public health detailing effort, a strategy modeled on pharmaceutical detailing (for details, see Category B application).[13]