ECHPP Project

Workbook #2: GOALS, STRATEGIES, AND OBJECTIVES

(4/15/2011)

Required Intervention #1: "Routine, opt-out screening for HIV in clinical settings"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 1.1: Expand rates of routine opt-out HIV screening in SFDPH primary care settings and SF General Hospital (SFGH).	**Strategy 1.1.1**: Educate clinicians on the CDC screening guidelines and promote implementation of the new guidelines using a public health detailing approach. **Strategy 1.1.2:** Work with the primary care clinics and SFDPH departments and clinics to identify and address barriers to expansion of routine opt-out HIV screening. **Strategy 1.1.3:** Promote HIV screening among patients, using fliers, posters, or other educational materials as appropriate for each setting. **Strategy 1.1.4:** Support a routine HIV screening champion at Jail Health Services to promote screening and address barriers to screening with the jails.	**Objective 1.1.1:** By September 30, 2011, conduct 18,203 tests within selected SFDPH primary care settings and SFDPH departments/clinics (a 46% increase over the 2009 baseline of 12,468).	CDC (Expanded Testing Initiative), NIH, possible ECHPP funding for educational materials	1.1.1 HPS medical testing data
• With whom you plan to partner: San Francisco General Hospital, DPH Community-Oriented Primary Care clinics, Jail Health Services, SF Community Clinic Consortium • If it is a new or existing partnership: New partnerships • If you will subcontract with the partner, the amount: None				

Required Intervention #2: "HIV testing in non-clinical settings to identify undiagnosed HIV infection"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 2.1: Scale up community-based HIV testing to 30,000 tests per year among MSM, IDU, and transfemales who have sex with males (TFSM).	**Strategy 2.1.1**: Increase funding for community-based HIV testing targeting MSM, IDU, and transfemales. **Strategy 2.1.2:** Require that counseling be limited to no more than 1/3 of HIV-negative tests. **Strategy 2.1.3:** Promote HIV testing every 6 months among MSM, IDU, and TFSM.	**Objective 2.1.1:** By July 1, 2011, fund at least 2 programs to provide citywide community-based HIV testing. **Objective 2.1.2:** By July 1, 2011, fund at least 4 special projects that will provide testing to African American MSM, Latino MSM, MSM in general, and transfemales. **Objective 2.1.3:** By September 30, 2011, implement health communication and public information campaigns to promote testing every 6 months among MSM, IDU, and TFSM.*	CDC base, SF General Fund, SAMHSA HIV set-aside	2.1.1 and 2.1.2 Existence of award letters for HPS RFP #21-2010; 2.1.3 formative research results regarding appropriateness of campaigns for target audience; existence of health communication campaign materials

- With whom you plan to partner: Community-based partners TBD based on results of HPS RFP, available July 1
- If it is a new or existing partnership: TBD
- If you will subcontract with the partner, the amount: Precise funding amounts TBD (approximately $2 million)

*This objective is purposefully stated broadly, because we have not yet determined which agencies will be providing HIV testing (the results from our RFP process are pending). Once we determine this, we can then decide whether to support individual agencies to do separate campaigns targeting their specific populations (depending on what was proposed in their applications) or whether HPS should work with a consultant to design one citywide campaign. This objective can be updated and made more specific once the RFP process is complete (July 1, 2011).

Required Intervention #3: "Condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 3.1: Increase access to free condoms among MSM, IDU, and TFSM.	**Strategy 3.1.1**: Explore the cost and feasibility of implementing a condom dispenser program strategically targeting high-risk MSM, IDU, and TFSM in venues such as bars, restaurants, and movie theaters. **Strategy3.1.2:** Require all HPS-funded programs and HHS-funded Centers of Excellence (CoEs) to make free condoms available to participants. **Strategy 3.1.3:** Continue current levels of community-wide condom distribution targeting MSM (approximately 450,000 condoms per year).	**Objective 3.1.1:** By September 30, 2011 decide whether to implement a condom dispenser program. **Objective 3.1.2:** By July 1, 2011, all HPS-funded agencies and HHS-funded Centers of Excellence (CoEs) will make free condoms available to participants.	CDC base, SF General Fund	3.1.1 Condom dispenser assessment and decision; 3.1.2 All agencies have budget line items for condoms or receive condoms through HPS's condom availability program. In addition, NHBS data can be used to monitor the goal for MSM and IDU.
• With whom you plan to partner: Community-based partners TBD based on results of HPS RFP, available July 1 • If it is a new or existing partnership: TBD • If you will subcontract with the partner, the amount: Precise funding amounts TBD based on RFP applications and requests for condom supplies and distribution				

Required Intervention #4: "Provision of Post-Exposure Prophylaxis to populations at greatest risk"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 4.1: Maintain PEP efforts at current levels.	**Strategy 4.1.1**: Support SFDPH STD Prevention and Control to provide PEP to individuals who qualify based on local PEP screening criteria.	**Objective 4.1.1:** By September 30, 2011 provide PEP to at least 200 individuals.	CDC base	4.1.1 PEP program data
• With whom you plan to partner: SFDPH STD Prevention and Control • If it is a new or existing partnership: Existing • If you will subcontract with the partner, the amount: $78,071				

Required Intervention #5: "Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 5.1: Improve data collection and tracking for HIV testing in medical settings to facilitate measurement of HIV screening rates.	**Strategy 5.1.1**: Work with SFDPH primary care clinics, SFGH department and clinics, and the SFDPH electronic medical record staff to ensure HIV screening data is collected and reported accurately and consistently.	**Repeated objective from Required Intervention #1** **Objective 5.1.1:** By September 30, 2011, establish policies and mechanisms for distinguishing between screening and diagnostic testing, and between newly diagnosed and previously diagnosed, within existing data systems.	CDC (Expanded Testing Initiative)	5.1.1 HPS medical testing data protocols
Goal 5.2: Ensure that all individuals who learn they are HIV-infected are offered partner services.	**Strategy 5.2.1**: Require all HPS-funded community-based testing programs to participate in the SFDPH partner services program.	**Repeated objective from required intervention #12** **Objective 5.2.1:** By September 30, 2011, all HPS-funded community-based HIV testing sites will have systems in place to offer partner services to all clients newly diagnosed with HIV.	CDC base, CDC Expanded Testing Initiative Part B	5.2.1 **Agency partner services protocols**
Goal 5.3: Establish policies to promote primary care homes for uninsured San Francisco residents.	**Strategy 5.3.1**: Require all HPS-funded programs to provide information to clients on Healthy San Francisco (and/or other resources for health coverage).	**Objective 5.3.1:** By September 30, 2011, provide Healthy San Francisco informational materials and referral protocols to all HPS-funded agencies.	CDC base	5.3.1 Healthy San Francisco materials and protocols provided to programs
Goal 5.4: Improve relations between law enforcement and users of syringe access and disposal services.	**Strategy 5.4.1**: Provide training to law enforcement on syringe access and disposal programs.	**Objective 5.4.1:** By September 30, 2011, complete a police training video on syringe access and disposal programs.	ECHPP	5.4.1 Video
• With whom you plan to partner: SFDPH primary care clinics, SFGH department and clinics, the SFDPH electronic medical record staff, funded agencies TBD based on RFP process, police department • If it is a new or existing partnership: Most are existing partnerships; additional partnerships TBD based on RFP process • If you will subcontract with the partner, the amount: None				

Required Intervention #6: "Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care"

See Appendix 1 for a more complete description of proposed linkage to care efforts.

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 6.1: Increase the percentage of clients testing HIV-positive at community-based HIV testing sites who are linked to HIV primary care within 3 months of diagnosis.	**Strategy 6.1.1**: Implement a new SFDPH program that will directly offer linkage to care and treatment, partner services, and prevention with positives (PWP) services to all clients diagnosed at community-based HIV testing sites. (See also Required Intervention #12) **Strategy 6.1.2:** Develop and implement a names-based HIV prevention service utilization data system for all HPS-supported programs to facilitate improved provision and tracking of linkage to care. (See also Required Intervention #7)	**Objective 6.1.1:** By September 30, 2011, 85% of clients testing HIV-positive in community-based sites will be offered linkage to care. **Objective 6.1.2:** By September 30, 2011, 65% of clients testing newly HIV-positive at HPS-supported programs will be linked to care within 3 months of diagnosis. **Objective 6.1.3:** By July 1, 2011, have in place a plan for the names-based data system. (See also Required Intervention #7)	CDC base, SF General Fund, SAMHSA set-aside	6.1.1 HPS HIV community-based testing data; 6.1.2 Match with HARS data; 6.1.3 Names-based system plan
Goal 6.2: Increase the percentage of clients testing HIV-positive in non-HIV-specialty medical settings who are linked to HIV primary care within 3 months of diagnosis.	**Strategy 6.2.1**: Implement a new DPH-wide PHAST program (see Situation Analysis for description) to provide linkage to care for people testing newly HIV-positive in DPH medical settings.	**Objective 6.2.1:** By September 30, 2011, at least 80% of newly diagnosed HIV-infected persons will be linked to HIV primary care within 3 months of diagnosis.	CDC (Expanded Testing Initiative Part B)	6.2.1 HIV/AIDS Reporting System
• With whom you plan to partner: Community-based partners TBD based on results of HPS RFP, available July 1 • If it is a new or existing partnership: TBD • If you will subcontract with the partner, the amount: Services will be provided by DPH in community-based settings, so no funds will be subcontracted.				

Required Intervention #7: "Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons"

See Appendix 1 for a more complete description of proposed re-engagement in care efforts.

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 7.1: Decrease the percentage of HIV-positive individuals who are not in care.*	**Strategy 7.1.7**: Develop and implement a new SFDPH program to provide navigation to clients not in care. **Strategy 7.1.2:** Develop and implement a names-based HIV prevention service utilization data system for all HPS-supported programs to facilitate improved provision and tracking of individuals not in care and re-engagement in care. (See also Required Intervention #6)	**Objective 7.1.1:** By July 1, 2011, complete the development of training manuals, curricula, and protocols for the navigation program. **Objective7.1. 2:** By September 30, 2011, pilot test the navigation program with a limited number of providers. **Objective 7.1.3:** By July 1, 2011, have in place a plan for the names-based data system. (See also Required Intervention #6)	ECHPP, sustained with CDC base	**7.1.1 Program materials; 7.1.2 Pilot testing documentation; 7.1.3 Names-based system plan**
• With whom you plan to partner: Community-based partners TBD based on results of HPS and HHS RFPs, available July 1; HIV Health Services; • If it is a new or existing partnership: TBD • If you will subcontract with the partner, the amount: Services described in the strategies and objectives will be provided by DPH, so no funds will be subcontracted.				

***"Not in care" is defined as clients who were lost to care, individuals who were never in care, and clients who are intermittent care seekers.**

Required Intervention #8: "Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 8.1: Promote acceptance and implementation of the SFDPH HIV treatment guidelines in the HIV medical provider community, public and private.	**Strategy 8.1.1**: Use a public health detailing approach to develop buy-in, acceptance, and implementation of the SFDPH HIV treatment guidelines among HIV primary care providers and to address barriers to implementation.	**Objective 8.1.1:** By September 30, 2011 convene at least one meeting with HIV primary care providers to discuss and promote the San Francisco guidelines.	ECHPP; sustained with CDC (Expanded Testing Initiative)	**8.1.1 Documentation of meetings**
• With whom you plan to partner: San Francisco General Hospital, DPH Community-Oriented Primary Care clinics, Jail Health Services, SF Community Clinic Consortium • If it is a new or existing partnership: New partnerships • If you will subcontract with the partner, the amount: None				

Required Intervention #9: "Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 9.1: Increase treatment adherence support for clients with unsuppressed viral load.	**Strategy 9.1.1:** Require all HPS-funded PWP programs to offer treatment adherence support to all clients with unsuppressed viral load. **Strategy 9.1.2:** Require all HHS-funded CoEs and HPS-funded PWP programs to offer treatment adherence support to clients with unsuppressed viral load.	**Objective 9.1.1:** By September 30, 2011, 85% of clients with unsuppressed viral load in HPS-funded PWP programs will receive at least one treatment adherence intervention. **Objective 9.1.2:** By September 30, 2011, 75% of clients with unsuppressed viral load in HHS-funded CoEs will be screened for barriers to adherence.	CDC base, HRSA Ryan White	**9.1.1 Program monitoring data; 9.1.2 ARIES**
• With whom you plan to partner: Community-based partners TBD based on results of HPS and HHS RFPs, available July 1; HIV Health Services • If it is a new or existing partnership: TBD • If you will subcontract with the partner, the amount: Specific amounts for treatment adherence cannot be determined, because it is a separate service modality. Overall amounts for PWP can be provided once the RFP process is complete (approximately $1.3 million).				

Required Intervention #10: "Implement STD screening according to current guidelines for HIV-positive persons"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 10.1: Integrate STD screening and treatment into programs for HIV-positive persons.	**Strategy 10.1.1:** Require all HPS-funded PWP programs to include an STD screening and treatment component, on site or through referral. **Strategy 10.1.2:** Require that CoE clients be offered STD screening for gonorrhea and syphilis upon intake, and annually thereafter.	**Objective 10.1.1:** By September, 2011, all HPS-funded PWP programs will have in place protocols for linking clients to STD screening and treatment **Objective 10.1.2:** By September 30, 2011, 85% of CoE clients will have been offered STD screening upon intake, as measured by ARIES. **Objective 10.1.3:** By September 30, 2011, 85% of sexually active CoE clients will have received STD screening within the prior year.	CDC base, HRSA Ryan White, Minority AIDS Initiative	10.1.1 Linkage protocols; 10.1.2 and 10.1.3 ARIES
Goal 10.2: Implement STD screening guidelines for HIV-positive individuals that are based on the current local STD and HIV epidemiology.	**Strategy 10.2.1**: Update local guidelines for STD screening and treatment for HIV-positive individuals.	**Objective 10.2.1:** By July 1, 2011, update the guidelines for STD screening and treatment for HIV-positive people.	**PCSI, CDC STD funds**	**10.2.1 Updated guidelines**
• With whom you plan to partner: SFDPH STD Prevention and Control; HIV Health Services; Community-based partners TBD based on results of HPS and HHS RFPs, available July 1 • If it is a new or existing partnership: Existing • If you will subcontract with the partner, the amount: None				

Required Intervention #11: "Implement prevention of perinatal transmission for HIV-positive persons"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 11.1: Maintain BAPAC efforts at current levels.	**Strategy 11.1.1:** Provide comprehensive preconception counseling and prenatal care to women and families infected and affected by HIV.	**Objective 11.1.1:** Between October 1, 2010 and September 30, 2011, provide prenatal care to 10 HIV-positive pregnant SF residents* at SF General Hospital. **Objective 11.1.2:** Between October 1, 2010 and September 30, 2011, provide preconception counseling to 12 women/couples affected by HIV (SF residents*) at SF General Hospital. **Objective 11.1.3:** Between October 1, 2010 and September 30, 2011, have 0 babies born with HIV in SF.	**Ryan White Part A, Haas Foundation**	**10.1.1 and 10.1.2: BAPAC program records** **10.1.3 HIV Surveillance data**
• With whom you plan to partner: BAPAC • If it is a new or existing partnership: Existing • If you will subcontract with the partner, the amount: None				

*Note: BAPAC also provides services to non-SF residents because other California counties do not have specialty care for pregnant HIV-positive women.

Required Intervention #12: "Implement ongoing partner services for HIV-positive persons"

See Appendix 1 for a more complete description of proposed partner services efforts.

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 12.1: All individuals testing positive for HIV in San Francisco, regardless of where they are tested, will be offered partner services.	**Strategy 12.1.1**: Develop a new SFDPH program that will offer linkage to care and treatment, partner services, and prevention with positives (PWP) services to all clients diagnosed at community-based HIV testing sites. (See also Required Intervention #6) **Strategy 12.1.2:** Expand partner services for people testing HIV-positive in SFDPH medical settings.	**Objective 12.1.1:** By July 2011, SFDPH will hire at least 3.0 FTE additional PS field staff. **Objective 12.1.2:** By September 30, 2011, all HPS-funded community-based HIV testing sites will have systems in place to offer partner services to all clients newly diagnosed with HIV. **Objective 12.1.3:** By September 30, 2011, SFDPH primary care and SFGH departments/clinics will have systems in place to offer partner services to all clients newly diagnosed with HIV (systems might include a role for Community-Oriented Primary Care Behaviorists).	CDC base, CDC Expanded Testing Initiative Part B	**12.1.1 Hiring letters; 12.1.2 and 12.1.3 Agency partner services protocols**
Goal 12.2: Increase acceptability of partner services among MSM in San Francisco.	**Strategy 12.2.1**: Identify MSM community concerns and barriers to using PS. **Strategy 12.2.2:** Address concerns and barriers through community education or other appropriate means.	**Objective 12.2.1:** Conduct at least two focus groups with MSM to explore barriers to understanding and accessing partner services.	**CDC base**	**12.2.1 Focus group analysis**
• With whom you plan to partner: SFDPH STD Prevention and Control; Community-based partners TBD based on results of HPS and HHS RFPs, available July 1 • If it is a new or existing partnership: Existing partnership with STD Prevention and Control; community-based partnerships TBD • If you will subcontract with the partner, the amount: $337,000 to STD Prevention and Control				

Required Intervention #13: "Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 13.1: Include behavioral risk interventions as one component of a comprehensive approach to prevention for PLWHA.	**Strategy 13.1.1**: Implement the following seven required program components for HPS-funded PWP programs: (1) treatment adherence, (2) engagement in HIV care, (3) disclosure assistance, (4) health education/risk reduction to address HIV risk behavior, (5) linkage to ancillary services, and (6) STD, viral hepatitis, and tuberculosis screening and treatment, and (7) comprehensive risk counseling services (CRCS).	**Objective 13.1.1:** By July 1, 2011, fund 7-8 PWP programs that include the seven required program components. **Objective 13.1.2:** By July 1, 2011, fund 4-8 special projects to address health disparities that include behavioral risk screening and risk reduction services for HIV-positive persons.	CDC, SF General Fund	13.1.1 and 13.1.2 Award letters for HPS RFP #21-2010
• With whom you plan to partner: Community-based partners TBD based on results of HPS RFP, available July 1 • If it is a new or existing partnership: TBD • If you will subcontract with the partner, the amount: TBD				

Required Intervention #14: "Implement linkage to other medical and social services for HIV-positive persons"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 14.1: Scale up efforts to address substance use within HIV prevention programs for MSM.	**Strategy 14.1.1**: Increase the focus on addressing substance use as a driver of new HIV infections within health education/risk reduction programs for MSM.	**Objective 14.1.1:** By July 1, 2011, fund at least 2 programs to provide intensive behavioral services to reduce the effects of substance use on HIV risk among MSM, including MSM who inject drugs.	CDC base, SF General Fund	14.1.1 Award letters for HPS RFP #21-2010
• With whom you plan to partner: Community-based partners TBD based on results of HPS RFP, available July 1 • If it is a new or existing partnership: TBD • If you will subcontract with the partner, the amount: TBD				

Recommended Intervention #15: "Condom distribution for the general population"

The goal for required intervention #3 also applies: "Goal 1: Increase access to free condoms among MSM, IDU, and TFSM,**" because condoms will be made available in venues that the general population also frequents.**

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 15.1: Increase access to the Female 2 condom (FC2).	**Strategy 15.1.1**: Provide free FC2's to San Francisco residents.	**Objective 15.1.1:** By September 30, 2011, distribute 37,500 FC2's.	MAC AIDS Fund	15.1.1 Condom distribution logs
• With whom you plan to partner: SFDPH STD Prevention and Control • If it is a new or existing partnership: Existing • If you will subcontract with the partner, the amount: None				

Recommended Intervention #16: "HIV and sexual health communication or social marketing campaigns targeted to relevant audiences"

This intervention repeats a goal, objective, and strategy from required intervention #2 (see below).

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 16.1: Scale up community-based HIV testing to 30,000 tests per year among MSM, IDU, and transfemales who have sex with males (TFSM).	**Strategy 16.1.1:** Promote HIV testing every 6 months among MSM, IDU, and TFSM.	**Objective 16.1.1:** By September 30, 2011, implement health communication and public information campaigns to promote testing every 6 months among MSM, IDU, and TFSM.*	CDC base, SF General Fund (possible use of ECHPP funds for social marketing)	16.1.1 Formative research results regarding appropriateness of campaigns for target audience; existence of health communication campaign materials
• With whom you plan to partner: Community-based partners TBD based on results of HPS RFP, available July 1 • If it is a new or existing partnership: TBD • If you will subcontract with the partner, the amount: TBD				

*This objective is purposefully stated broadly, because we have not yet determined which agencies will be providing HIV testing (the results from our RFP process are pending). Once we determine this, we can then decide whether to support individual agencies to do separate campaigns targeting their specific populations (depending on what was proposed in their applications) or whether HPS should work with a consultant to design one citywide campaign. This objective can be updated and made more specific once the RFP process is complete (July 1, 2011).

Recommended Intervention #17: "Clinic-wide or provider delivered evidence-based HIV prevention interventions for HIV-positive patients and patients at highest risk of acquiring HIV"

This intervention repeats a goal from required intervention #9 (see below).

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 17.1: Increase treatment adherence support for clients with unsuppressed viral load.	**Strategy 17.1.1**: Provide training to HIV prevention program staff on evidence-based treatment adherence interventions.	**Objective 17.1.1:** By September 30, 2011, develop a training component on evidence-based treatment adherence interventions for all HIV prevention providers funded by SFDPH.	**CDC**	17.1.1 Existence of training curriculum
• With whom you plan to partner: City College of San Francisco and other training providers • If it is a new or existing partnership: New • If you will subcontract with the partner, the amount: TBD				

Recommended Intervention #18: "Community interventions that reduce HIV risk"

Goal	Strategies	Objectives	Funding Source	Data Sources
Repeated goal from Recommended Intervention #16 **Goal 18.1**: Scale up community-based HIV testing to 30,000 tests per year among MSM, IDU, and transfemales who have sex with males (TFSM).	**Repeated strategy from Recommended Intervention #16** **Strategy 18.1.1**: Promote HIV testing every 6 months among MSM, IDU, and TFSM.	**Complements objective from Recommended Intervention #16** **Objective 18.1.1:** By July 1, 2011, fund at least one community-level intervention to promote testing every 6 months among MSM, IDU, and TFSM.	**CDC**	18.1.1 Award letters for HPS RFP #21-2010
• With whom you plan to partner: Community-based partners TBD based on results of HPS RFP, available July 1 • If it is a new or existing partnership: TBD • If you will subcontract with the partner, the amount: TBD				

Recommended Intervention #19: "Behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV; particularly those in an HIV-serodiscordant relationship"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 19.1: Reduce drivers of HIV among HIV-negative persons at high risk for acquiring HIV.	**Strategy 19.1.1**: Implement programs to address the drivers of HIV in San Francisco – crack/cocaine use, heavy alcohol use, methamphetamine use, poppers use, gonorrhea, and/or multiple partners.	**Objective 19.1.1:** By July 1, 2011, fund 2-3 programs to address drivers of HIV among MSM.	**CDC, SF General Fund**	19,1.1 Award letters for HPS RFP #21-2010
Goal 19.2: Include behavioral risk interventions as one component of a comprehensive approach to HIV prevention for people at risk for HIV.	**Strategy 19.2.1**: Implement programs that take a holistic approach to HIV prevention, including behavioral screening and risk reduction, in communities with the greatest HIV disparities.	**Objective 19.2.1:** By July 1, 2011 fund 1-2 programs for African American MSM. **Objective 19.2.2:** By July 1, 2011 fund 1-2 programs for Latino MSM. **Objective 19.2.3:** By July 1, 2011 fund 1-2 programs for MSM (general population). **Objective 19.2.4:** By July 1, 2011 fund 1-2 programs for transfemales who have sex with males.	**CDC, SF General Fund**	All objectives: Award letters for HPS RFP #21-2010
• With whom you plan to partner: Community-based partners TBD based on results of HPS RFP, available July 1 • If it is a new or existing partnership: TBD • If you will subcontract with the partner, the amount: TBD				

Recommended Intervention #20: "Integrated hepatitis, TB, and STD testing, partners services, vaccination, and treatment for HIV infected persons, HIV-negative persons at highest risk of acquiring HIV, and injection drug users according to existing guidelines"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 20.1: Expand DPH systems and capacity to monitor "real-time" disease trends in order to scale up and support the implementation and sustainability of a syndemic approach to the prevention of HIV/AIDS, viral hepatitis, STDs, and TB in SF.	**Strategy 20.1.1**: Analyze surveillance data across diseases to identify syndemics, possible clusters of disease, and trends in populations at risk. **Strategy 20.1.2:** Develop clinical guidelines for integrated prevention, screening, and treatment for HIV/AIDS, viral hepatitis, STDs, and TB. **Strategy 20.1.3:** Improve DPH data systems to support program collaboration and service integration.	**Objective 20.1.1:** By September 30, 2011, complete a preliminary data matching and analysis project across the four disease surveillance databases. **Objective 20.1.2:** By September 30, 2011, complete draft clinical guidelines. **Objective 20.1.3:** By September 30, 2011, develop preliminary recommendations for improving policies and procedures for data sharing across DPH sections.	**CDC (PCSI grant)**	20.1.1 PCSI assessment results, 20.1.2 clinical guidelines document, 20.1.3 recommendations document
• With whom you plan to partner: HIV Health Services, TB Control, STD Prevention and Control, Communicable Disease and Prevention, SFDPH laboratories, Surveillance sections for STD, HIV, TB, and hepatitis • If it is a new or existing partnership: New with the PCSI grant • If you will subcontract with the partner, the amount: None				

Recommended Intervention #21: "Targeted use of HIV and STD surveillance data to prioritize risk reduction counseling and partner services for persons with previously diagnosed HIV infection with a new STD diagnosis, and persons with a previous STD diagnosis who receive a new STD diagnosis"

No goals or objectives at this time. The SFDPH Prevention and Control Section has applied for a grant to provide risk reduction counseling (motivational interviewing) to MSM diagnosed with rectal STDs to prevent rectal reinfection and HIV seroconversion, but identification of eligible participants will be based on MSM seeking services not surveillance data.

Recommended Intervention #22: "For HIV-negative persons at highest risk for HIV, broadened linkages to and provision of services for social factors impacting HIV incidence such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and others"

The goal, strategy, and objective for intervention #14 (see below) also applies to this intervention, because the efforts will reach both HIV-positive and high-risk HIV-negative MSM. SF is committed to linkages to a broad range of services for social factors impacting HIV incidence. However, at this time, we do not have the resources to measure/track linkages to multiple services and instead will focus on linkages to substance use services, as substance use has been shown to be directly linked to HIV seroconversion in SF.

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 22.1: Scale up efforts to address substance use within HIV prevention programs for MSM.	**Strategy 22.1.1**: Increase funding for health education/risk reduction programs for MSM that address substance use as a driver of new HIV infections.	**Objective 22.1.1:** By July 1, 2011, fund at least 2 programs to provide intensive behavioral services to reduce the effects of substance use on HIV risk among MSM, including MSM who inject drugs.	CDC base, SF General Fund	22.1.1 Award letters for HPS RFP #21-2010
• With whom you plan to partner: Community-based partners TBD based on results of HPS RFP, available July 1 • If it is a new or existing partnership: TBD • If you will subcontract with the partner, the amount: TBD				

Recommended Intervention #23: "Brief alcohol screening and interventions for HIV-positive persons and HIV-negative persons at highest risk of acquiring HIV"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 23.1: Improve community-based HIV prevention provider knowledge, awareness, and skills to provide alcohol screening and interventions.	**Strategy 23.1.1**: Train HIV prevention providers on alcohol screening and intervention.	**Objective 23.1.1:** By September 30, 2011, develop a required training curriculum for HPS-funded providers that includes approaches to assessment and intervention for alcohol use.	CDC supplemental	23.1.1 Training curriculum
Goal 23.2: Expand the portfolio of evidence-based interventions for brief alcohol screening and intervention for HIV-negative gay and bisexual men.	**Strategy 23.2.1**: Identify relevant existing interventions and gaps in research and program models.	**Objective 23.2.1:** By September 30, 2011, complete a literature review. **Objective 23.2.2:** By September 30, 2011, apply for funding (contingent on availability) to develop and/or adapt an evidence-based intervention.	**Various research funding**	**23.2.1 Literature review; 23.2.2 funding application**
• With whom you plan to partner: Research Unit within HPS • If it is a new or existing partnership: Existing • If you will subcontract with the partner, the amount: None				

Recommended Intervention #24: "Community mobilization to create environments that support HIV prevention by actively involving community member in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among their family, friends, and neighbors"

No goals and objectives at this time. The results of our RFP process are pending. Some applicants may propose community mobilization efforts, but funding determinations have not yet been made.

Innovative Intervention #25: "Pre-exposure prophylaxis (PrEP)"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 25.1: Assess the feasibility and cost of PrEP.	**Strategy 25.1.1**: Contract with a consultant to explore feasibility and cost of PrEP. **Strategy 25.1.2**: Contingent on funding, implement a PrEP demonstration project for 400 high-risk MSM and transfemales.	**Objective 25.1.1:** Complete a PrEP assessment by May 1, 2011. **Objective 25.1.2:** Develop a PrEP implementation plan by July 1, 2011.	CDC supplemental	25.1.1 PrEP assessment, 25.1.2 PrEP plan
• With whom you plan to partner: Research Unit within HPS • If it is a new or existing partnership: Existing • If you will subcontract with the partner, the amount: None				

Innovative Intervention #26: "Syringe Access and Disposal"

Goal	Strategies	Objectives	Funding Source	Data Sources
Goal 26.1: Improve syringe access and disposal for IDUs.	**Strategy 26.1.1**: Require all HPS-funded programs to provide syringe access and disposal services to IDU clients during the course of providing other services.	**Objective 26.1.1:** By September 30, 2011, develop a training for HPS-funded providers on syringe access and disposal.	SF General Fund	26.1.1 Training curriculum
• With whom you plan to partner: Community-based partners TBD based on results of HPS RFP, available July 1 • If it is a new or existing partnership: TBD • If you will subcontract with the partner, the amount: TBD (approximately $1.1 million)				

National Strategic Goals Tool

Summary

Although there is no "magic formula" for determining the optimal combination of cost-effective and efficacious HIV prevention approaches, ample evidence exists in San Francisco to support the SF HIV/AIDS Strategy described in this plan. The SF HIV/AIDS Strategy was developed by taking into account the effectiveness, scalability, cost, and potential impact of each intervention. Our goal is to implement a "high impact prevention" strategy by maximizing the effectiveness of our combination approach.

HIV is no longer epidemic in SF; it is endemic, and thus requires a shift in how we approach HIV prevention. When HIV was epidemic, behavioral interventions for HIV-positive and high-risk HIV-negative people were the centerpiece of our strategy. In 2011, it is apparent that we have maximized the impact of behavioral interventions – they are not effectively addressing the needs of the 500 – 1,000 people who are becoming infected each year in SF. Therefore, we need to implement a more upstream, structural approach to reducing new HIV infections. The SF HIV/AIDS Strategy achieves this by implementing a combination of interventions that create a safer environment for sex, such that even when unprotected sex does happen, the chance of transmitting/acquiring HIV is reduced. Specifically, the continuum of services described for HIV-positive people from diagnosis (HIV testing) through accessing and maintaining care and treatment is designed to increase individual and community viral load suppression, which is both good for individual health and prevents HIV.

SF still needs some level of behavioral interventions to maintain levels of safer sex within communities of MSM, IDU, and TFSM. The benefits of the new upstream approach will not be realized if unprotected sex increases. Therefore, SF will continue to support behavioral interventions for HIV-positive and HIV-negative people, at lower levels, but in a more focused way. Such interventions will focus on the highest risk individuals, and groups with the greatest HIV disparities (HIV-positive individuals with unsuppressed viral load, MSM overall, African American MSM, Latino MSM, TFSM overall, and MSM substance users).

Finally, the SF HIV/AIDS Strategy seeks to improve in areas where we have already shown substantial success. NHBS data shows that MSM and IDU report high levels of access to condoms and IDU report high levels of access to syringes. With a relatively small increase in investment, we can strive to increase access even further, and potentially realize a great impact. Other successful efforts, such as perinatal prevention and PEP, will be maintained at current levels.

In summary, the SF HIV/AIDS Strategy:
1. Scales up interventions for HIV-positive people that will ultimately reduce community viral load (CVL), such as retention/re-engagement and treatment adherence
2. Scales down and re-focuses behavioral interventions to populations where they can have the most impact
3. Scales up interventions that are not costly but have the potential for large impact, such as condoms distribution and syringe access
4. Maintains successful cost-effective efforts, such as perinatal prevention and PEP

The needs in SF are clear. HIV is endemic. MSM and IDU are not testing frequently enough, based on NHBS data (the SF recommendation is to test every 6 months). A substantial percentage of HIV-positive people are not being linked to care in a timely manner, are not being retained in care, and/or are not

accessing treatment. Substance use and other factors are driving new HIV infections but services to address them are insufficient. HIV-related disparities still exist among MSM overall, African American and Latino MSM, MSM substance users, and TFSM. The SF HIV/AIDS Strategy was developed in direct response to these identified needs.

For a detailed description of the SF HIV/AIDS Strategy and how the resources will shift, refer to Appendix 1.

Reducing New HIV Infections

1. Reduce the annual number of new HIV infections by 25% and reduce the HIV transmission rate by 30%

Current SF new HIV infections annually (2011): 723
SF transmission rate (2008): 3.98

HIV testing efforts as described in required interventions #1 and #2 will reduce new HIV infections because a new HIV diagnosis reduces risk behavior (Colfax et al, AIDS 2002). Efforts in the areas of retention/re-engagement (#7), treatment adherence (#9), expanding treatment access through implementing the SF treatment guidelines will lead to community viral load suppression and thus reduce the HIV transmission rate. This seamless continuum of evidence-based care/prevention services from time of diagnosis represents the optimal combination of services to diagnose the most individuals, early in the course of their disease, and support them to get into and stay in care. Focused behavioral interventions will address drivers of HIV among MSM and sexual risk behaviors among MSM, IDU, and TFSM, adding to the impact of the continuum of services for HIV-positive individuals.

SF currently has a strong model focused on interventions to reduce high-risk sexual behavior among HIV-negative MSM, IDU, and TFSM. Data suggest that the greatest unmet needs lie in HIV testing (70,000 more tests needed per year if all MSM, IDU, and TFSM were to test every 6 months, based on NHBS data from 2005 and 2008) and care/treatment (28% of those with known HIV-positive status have unsuppressed viral load, and 24% are not in care – see #7 for data sources). A scale-up of testing and the continuum of care/prevention for positives meets these needs.

In San Francisco, we need to prevention an additional 181 new infections and reduce the transmission rate by 1.19. With earlier diagnosis, fewer new infections will occur because people aware of their status take steps to not infect others. With increased care and treatment, fewer new infections will occur because there will be less viral burden in the community. We think we can achieve the 25% and 30% reductions, respectively, with the new emphasis on this combination of interventions.

SF will leverage funds from the Expanded Testing Initiative, CDC base funding, and third party billing for testing and care services. HIV Prevention and HIV Health Services will work closely as partners to ensure the continuum of care/prevention for positives is seamless and coordinated.

2. Increase the percentage of people living with HIV who know their serostatus to 90%

% of PLWHA aware of their status in SF: 80.0 - 84.9% (estimated)

Our two testing approaches (Interventions #1 and 2) as well as partner services (#12) complement each other to promote earlier diagnosis of new infections and also diagnose people with longer-standing infections who are unaware of their status. Community-based testing (Intervention #2) will focus on high-incidence populations (MSM, IDU, and TFSM), with a special emphasis on groups with HIV-related disparities (African American and Latino MSM). The vast majority of new HIV infections (96%; H. Fisher Raymond, presentation to HPPC, January 2011) occur in these populations. Routine screening in medical settings (Intervention #1) will complement this approach by reaching people who do not necessarily identify with one of these groups and who may not be aware of their risk, or for other reasons, may not seek out HIV testing on their own. Partner services (#12) will identify new cases through partner elicitation and notification. In concert, we anticipate that the planned scale-up these three interventions will help us reduce the unknown infection rate to 5.1% or lower. We have maximized cost-efficiency by scaling down counseling efforts within community-based testing (very costly) in order to increase the number of tests we are able to provide.

Data suggest that 70,000 more tests are needed per year if all MSM, IDU, and TFSM were to test every 6 months, based on NHBS data from 2005 and 2008. Intervention 2 will contribute an additional 20,000 tests annually toward addressing this gap. Intervention 1 will contribute approximately 6,000 tests toward addressing the gap in year 1, and more in subsequent years. Partner services will yield a low number of tests, but a high new positivity rate. Although a gap will still remain, this is the maximum level of resources we could allocate without compromising the impact of other interventions (for example, we would need to reduce allocations in PWP or HERR in order to pay for more testing, thus compromising their potential impact). Furthermore, it will take time to change the community norm such that testing every 6 months becomes a regular practice among MSM, IDU, and TFSM, so even if we funded sufficient testing services to address the entire 70,000 testing gap, it is unlikely that there would be that level of demand. Therefore, we believe these two interventions are at an appropriate scale.

SF will leverage funds from the Expanded Testing Initiative to support DPH medical settings to scale up routine screening and will support clinics via training and education to increase third party billing for HIV testing.

3. Increase the percentage of people newly diagnosed with HIV infection who have a CD4 count of 200 cells/µl or higher by 25%

The median CD4 count at diagnosis in SF is 403 (HIV/AIDS Epidemiology Annual Report, 2009). Individuals with lower CD4 counts at diagnosis are mostly likely testing late in the course of their infection. Nine percent of PLWHA in SF are late testers (that is, people who develop AIDS within 12 months of HIV diagnosis, with no prior HIV tests or an HIV-negative test more than 5 years prior to diagnosis) (HIV/AIDS Epidemiology Annual Report, 2009).

Routine opt-out screening and community-based testing (Interventions #1 and 2) will work together to result in earlier diagnosis. Specifically, health communication campaigns to increase testing frequency among MSM, IDU, and TFSM, coupled with the targeted use of RNA testing and other new testing technologies, will greatly increase early detection. Routine screening initially will find long-standing unknown infections, some proportion of which will have an initial CD4 count less than 200, but eventually will begin to identify people earlier in the course of their infection once fully implemented per the CDC recommendations.

SF will leverage funds from the Expanded Testing Initiative to support DPH medical settings to scale up routine screening and will support clinics via training and education to increase third party billing for HIV testing.

4. Reduce the proportion of MSM who reported unprotected anal intercourse during their last sexual encounter with a partner of discordant or unknown HIV status by 25%

SF will contribute toward this target by increasing access to condoms among MSM (Intervention #3) and behavioral risk interventions for HIV-positive and high-risk HIV-negative individuals (Interventions #13 and 19). Increasing condom distribution will help address any instances of unprotected sex that are due to lack of access. SF is proposing to scale down interventions #13 and 19, but focus them on MSM affected by the factors that have been shown to be driving new HIV infections (substance users, those with multiple partners, and those with gonorrhea). We do not anticipate a population-level 25% decrease in reported unprotected anal sex based on this approach, but given limited resources, a more cost-effective and efficacious approach to reducing new HIV infections is through an investment in the continuum of evidence-based care/prevention services from time of diagnosis, as described under Target 1.

In SF it has been shown that unprotected sex is not the only or necessarily even the primary factor contributing to new HIV infections. African American MSM, who report similar levels of risk behavior compared with other groups, nevertheless have higher HIV rates than other groups, probably due to high prevalence sexual networks (W. McFarland, presentation to HPPC, January 2009). Furthermore, having multiple anal sex partners is strongly and associated with HIV seroconversion, independent of whether the sex was protected or unprotected (SF 2010 HIV Prevention Plan, p. 123-124). By focusing the limited available resources on MSM affected by drivers, we anticipate that we can better address unmet needs in the MSM community and reduce unprotected sex among those at highest risk for seroconversion or transmission. In addition, behavioral risk reduction messages will be woven throughout all community-based programs (such as testing and prevention with positives) even though are not the focus.

The HIV Prevention Section is exploring ways to integrate HIV prevention into behavioral health services within DPH primary care settings, which if successful, could help leverage other funds and allow some services to be billed to third parties.

5. Reduce the proportion of IDU at risk for transmission/acquisition of HIV by XX% [Indicator TBD pending DHAP strategic plan]

Intervention #26, syringe access and disposal is a highly efficacious and cost-effective intervention that will help maintain (but probably not substantially reduce) SF's low rates of new HIV infections among IDUs, and by extension, heterosexual partners of IDUs. It cannot be overstated how critical this intervention has been and continues to be in SF's portfolio; early introduction of syringe exchange is widely believed to be responsible for the low rates of infections among IDUs and the fact that there is no heterosexual epidemic in SF. Any reduction in the available services threatens the successes we have achieved to date.

In SF, HIV transmission and acquisition among IDUs is primarily through sexual means, not through sharing of injection equipment. Therefore, the primary interventions that will contribute to reducing the proportion of IDUs at risk for transmission/acquisition of HIV are behavioral interventions (#13 and 19) for MSM, IDU, and TFSM injectors. These two interventions will work together and funds will be leveraged as described under Target 4 to reduce risk among IDUs.

6. Decrease the number of perinatally acquired pediatric HIV cases by 25%

SF has had no perinatal infections since 2004.We will continue our current level of funding to maintain this success.

Increasing Access to Care and Improving Health Outcomes for People Living with HIV

7. Reduce AIDS diagnoses by 25%

AIDS diagnoses in SF (2009): 225

AIDS diagnoses have been steadily declining since 1992, largely due to advances in treatment and improving treatment access (although not all groups have benefited equally – see disparities section). To reduce diagnoses further, SF will scale up treatment adherence interventions (#9) and widely promote the new SFDPH treatment guidelines (#8) which will expand treatment options to a greater number of HIV-positive people. Together, these two interventions will results in an increase in the percentage of PLWH on treatment and adhering, thus reducing AIDS diagnoses.

Substantial resources are already being invested in re-engagement and adherence interventions, but unmet needs remain. ART use among people living with HIV non-AIDS in San Francisco 46-68%, depending on the CD4 count, substantially lower than the 88-92% of people living with AIDS who are receiving ART (HIV/AIDS Epidemiology Annual Report, 2009). Our two-fold strategy to increase ART use – 1) educate providers about the SF guidelines for early ART initiation, which will increase the number and percentage of PLWH on voluntary treatment, and 2) scale up treatment adherence interventions, which will increase the number and percentage of PLWHA on treatment that are adhering – will reduce AIDS diagnoses.

SF will leverage Ryan White funds by working closely with the HIV Health Services Section to support jointly-funded treatment adherence efforts within the Centers of Excellence. Expanded Testing Initiative funds will also be leveraged. The ETI Director, while working in medical settings to promote routine opt-out screening, will also be promoting the treatment guidelines to clinicians within these settings.

8. Increase the percentage of persons diagnosed with HIV who are linked to clinical care as evidenced by having a CD4 count or viral load measure within 3 months of HIV diagnosis to 85%

SF 3-month linkage to care rate (2009): 74%

Intervention #6, linkage to care, is embedded within a seamless continuum of services that starts with HIV diagnosis. Therefore, this intervention will work in concert with HIV testing (#1 and 2) and retention/re-engagement (#7) to result in improved linkage rates. Community-based testing sites will be required to work with the DPH EASE Program to link positive testers to care, and the navigation unit of the EASE Program will provide more intensive outreach or other needed efforts if the linkage unit is unable to successfully link the client to care.

Although existing efforts have shown an outstanding success rate – 74% of newly diagnosed individuals linked to care within 3 months, citywide – the other 26% have multiple barriers to access (e.g., substance use, mental health, stigma) that need a more intensive approach. Thus DPH is investing substantial resources in these three interventions, and will be directly providing linkage to care to people testing HIV-positive.

Resources from the Expanded Testing Initiative Part B will be leveraged to support linkage to care efforts.

9. Increase by 10% the percentage of HIV-diagnosed persons in care whose most recent viral load test in the past 12 months was undetectable

% of HIV-diagnosed person with undetectable viral load: 72%

The percentage of PLWHA with undetectable viral load and mean community viral load are key indicators for SF and success with these indicators will represent a big achievement for both care and prevention. Viral load suppression represents SF's community-level harm reduction approach; SF's goal is to create an environment in which if individuals default to unprotected sex, it will occur in a safer environment, where there is less chance of transmission due to increased viral load suppression.

The continuum of care/prevention interventions described in this plan will all lead sequentially to result in increased undetectable viral load. Testing (#1 and #2) is a necessary precursor to linkage to care (#6). Once in care, retention (#7), treatment access (#8), and treatment adherence (#9) are all critical for achieving viral load suppression. Retention and treatment adherence are influenced by other factors, thus the need for linkage to other services (#14).

28% of those diagnosed currently have unsuppressed viral loads in SF, in addition to the unsuppressed viral loads among people who do not know their status (thus the importance of testing). Many of these individuals have multiple barriers to retention and adherence (e.g., substance use, mental health, stigma) that need a more intensive approach. Thus DPH is investing substantial resources in this continuum of care/prevention.

Close collaboration with prevention and care will result in coordination of CDC and Ryan White funds to provide a seamless continuum of services.

10. Reduce the percentage of HIV-diagnosed persons in care who report unprotected anal or vaginal intercourse during the last 12 months with partners of discordant or unknown HIV status by 33%

SF will contribute toward this target by increasing access to condoms among HIV-positive persons (Intervention #3) and behavioral risk interventions for HIV-positive individuals (Intervention #13). Increasing condom distribution will help address any instances of unprotected sex that are due to lack of access. SF is proposing to scale down intervention #13, but will focus efforts on HIV-positive persons accessing care within the Centers of Excellence, other DPH clinics, or private medical practices. While some investment in behavioral risk interventions is needed for those individuals reporting serodiscordant unprotected sex, given limited resources, a more cost-effective and efficacious approach to reducing new HIV infections and addressing unmet prevention needs is through an investment in the continuum of evidence-based care/prevention services from time of diagnosis, which will reduce new infections by increasing viral load suppression.

Close collaboration with prevention and care resulted in a joint solicitation to put in place prevention with positives (PWP) programs within Centers of Excellence that will provide behavioral risk reduction interventions to clients in care.

11. By 2015, increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least two visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80%

DPH Centers of Excellence are currently required to maintain 90% of clients in care and are monitored on this outcome. Because Ryan White Program clients often face multiple challenges to engagement in primary care (e.g., mental health, substance use, homelessness), SF will scale up re-engagement in care efforts (#7) through implementation of the new DPH EASE Program (describe in Appendix 1) to address the citywide unmet need of 24% out of care. The EASE Program will work in concert with existing re-engagement efforts by providing a safety net for those clients who are not successfully reached by the PHAST Team, Centers of Excellence outreach efforts, or other programs. The EASE Program will provide a central point of coordination for re-engagement efforts in SF. These efforts will maximize their intended impact by increasing coordination and eliminating duplication, thereby ensuring that all Ryan White who are not in care are identified in a timely manner and provided appropriate services via whichever re-engagement team or individual has the best repertoire of skills and tools to meet the particular needs of the client.

Re-engagement efforts in SF will be funded by multiple sources, with a central point of coordination. ECHPP funds will be used to start up the EASE Program, which will then be sustained by CDC base funds, but the overall citywide re-engagement efforts (including the PHAST Team and other programs) will be funded by Ryan White and grants from various sources. All funds, across sources, will be used more efficiently due to coordination provided by EASE.

12. By 2015, increase the number of Ryan White clients with permanent housing from 82% to 86%

There are no specific elements in the SF ECHPP plan to address this goal. We are awaiting a definition of "permanent housing" from CDC or HHS.

Reducing HIV-Related Disparities

13. Increase the percentage of HIV-diagnosed gay and bisexual men with undetectable viral load by 20%

The seamless continuum of care/prevention services from time of diagnosis are designed to increase individual and community viral load suppression. These services include linkage to care (#6), re-

engagement in care (#7), and treatment adherence (#9) – all evidence-based interventions that lead to viral load suppression and improved health. Special efforts in these areas are directed at HIV-diagnosed gay and bisexual men. The Tenderloin Center of Excellence has a special emphasis on serving MSM, and the HPS-funded MSM special project addressed the needs of HIV-positive gay men. (These efforts are not the only efforts. Most care and prevention efforts, by default, are focused on gay and bisexual men in SF because they represent the vast majority of HIV/AIDS cases.)

Because gay/bisexual men represent approximately 86% of PLWHA in SF (2009 HIV/AIDS Epidemiology Annual Report), successful efforts directed at the outcome of viral load suppression in this population will have a substantial impact on HIV transmission. Currently, mean community viral load among gay/bisexual men is lower than the citywide mean (19,596 vs. 23,348; Das et al, 2010, PLoS One), but this is largely driven by gay/bisexual men who are privately insured and face fewer barriers to care than clients in Ryan White or other publicly funded services. The unmet need in SF is among gay/bisexual men accessing publicly funded services and those who don't access any services; HHS- and HPS-funded services along the continuum of care/prevention focus on these under-served populations.

Funds from several sources will be combined to create this seamless continuum of care – ECHPP, CDC base, Expanded Testing, and Ryan White.

14. Increase the percentage of HIV-diagnosed Blacks with undetectable viral load by 20%

The seamless continuum of care/prevention services from time of diagnosis are designed to increase individual and community viral load suppression. These services include linkage to care (#6), re-engagement in care (#7), and treatment adherence (#9) – all evidence-based interventions that lead to viral load suppression and improved health. Special efforts in these areas are directed at HIV-diagnosed Blacks. HHS funds an African American Center of Excellence, and the HPS-funded African American MSM special project addressed the needs of HIV-positive gay men. The EASE Program will provide services to HIV-diagnosed African Americans, including heterosexual non-IDUs who would not otherwise be reached by traditional HIV prevention services because of the low HIV incidence and prevalence in that population.

Currently, mean community viral load among African Americans is higher than the citywide mean (26,404 vs. 23,348; Das et al, 2010, PLoS One), probably due in part to barriers to accessing care and treatment. African Americans in SF have some of the lowest rates of ART use among all race/ethnicities, estimated at 84-89% of PLWA and at 63-66% among PLWH (2009 HIV/AIDS Epidemiology Annual Report). Scale up of the continuum of care/prevention services will help reduce these disparities.

Funds from several sources will be combined to create this seamless continuum of care – ECHPP, CDC base, Expanded Testing, and Ryan White.

15. Increase the percentage of HIV-diagnosed Latinos with undetectable viral load by 20%

The seamless continuum of care/prevention services from time of diagnosis are designed to increase individual and community viral load suppression. These services include linkage to care (#6), re-engagement in care (#7), and treatment adherence (#9) – all evidence-based interventions that lead to viral load suppression and improved health. Special efforts in these areas are directed at HIV-diagnosed Latinos. HHS funds a Latino Center of Excellence, and the HPS-funded Latino MSM special project addressed the needs of HIV-positive gay men. The EASE Program will provide services to HIV-diagnosed Latinos/as, including heterosexual non-IDUs who would not otherwise be reached by traditional HIV prevention services because of the low HIV incidence and prevalence in that population.

Currently, mean community viral load among Latinos is higher than the citywide mean (26,774 vs. 23,348; Das et al, 2010, PLoS One), probably due in part to barriers to accessing care and treatment. Latinos in SF have rates of ART use second only to whites, estimated at 87-92% of PLWA and at 65-71% among PLWH (2009 HIV/AIDS Epidemiology Annual Report). Scale up of the continuum of care/prevention services will help reduce the viral load disparities.

Funds from several sources will be combined to create this seamless continuum of care/prevention – ECHPP, CDC base, Expanded Testing, and Ryan White.

16. Reduce the disparity in HIV incidence for Blacks versus Whites (Black:White ratio of new infections) by 25%; By 2015, reduce the disparity in HIV incidence for Hispanics versus Whites (Hispanic:White ratio of new infections) by 25%

The approach to addressing HIV-related disparities among African Americans and Latinos in SF involves a primary focus on African American and Latino MSM, where most HIV incidence occurs. These populations will receive the core continuum of care/prevention services from time of as described earlier (#6, 7, 9, 12), with the addition of a primary prevention approach focusing on behavioral and community-level interventions (#13, 18, 19) for HIV-negative individuals, supported through HPS-funded special projects. A concerted effort to increase HIV testing among African American and Latino MSM will also be made, supported through the special projects, and also through citywide community-based testing and testing in medical settings (#1 and #2). In summary, these groups will receive the basic continuum of care/prevention (including specially targeted Centers of Excellence), but also an enhanced behavioral and community component that will try to reduce new infections through a primary prevention approach, going beyond the viral load suppression approach which will also reduce incidence among these groups through creating a safer environment for sex.

Data show that most new infections and diagnoses in SF are among whites, but African Americans males have the highest HIV incidence rate of all race/ethnicities (181 per 100,000 population), followed by Latino men (139 per 100,000 population) and white men (96 per 100,000 population) (2009 HIV/AIDS Epidemiology Report). This disparity will be addressed through the additional behavioral/community component as described above.

Funds from several sources will support the basic continuum of care/prevention. Because Ryan White funds can help support this continuum, it frees up CDC base funds to provide primary prevention for these groups, a service for which there are few other funding sources.

17. Reduce the disparity in HIV incidence for MSM versus other adults in the United States by 25%

MSM in SF will receive the core continuum of care/prevention services from time of as described earlier (#6, 7, 9, 12), with the addition of a primary prevention approach focusing on behavioral and community-level interventions (#13, 18, 19) for HIV-negative individuals, supported through HPS-funded special projects. A concerted effort to increase HIV testing among MSM will also be made, supported through the special projects, and also through citywide community-based testing and testing in medical settings (#1 and #2). In summary, MSM will receive the basic continuum of care/prevention (including specially targeted Centers of Excellence), but also an enhanced behavioral and community component that will try to reduce new infections through a primary prevention approach, going beyond the viral load suppression approach which will also reduce incidence among MSM through creating a safer environment for sex.

Data show that most new infections and diagnoses in SF are among MSM. In SF, MSM are more than 400 times more likely to contract HIV compared with men who have sex only with women (special data request, Epidemiology Section). This disparity will be addressed through the additional behavioral/community component as described above.

Funds from several sources will support the basic continuum of care/prevention. Because Ryan White funds can help support this continuum, it frees up CDC base funds to provide primary prevention for MSM, a service for which there are few other funding sources.

18. Ensure the percentage of persons diagnosed with HIV who have a CD4 count within 3 months of HIV diagnosis is 75% or greater for all racial/ethnic groups

The two primary interventions that will work together to ensure linkage to care, as measured by CD4 counts, are #6 (linkage to care) and #7(retention/re-engagement). The EASE Program description (Appendix 1) describes how these efforts complement each other and provide ongoing support to individuals post-diagnosis to ensure that barriers to accessing care are removed and that individuals are fully supported in obtaining HIV primary care.

With an unmet need of 24% not linked to care citywide within 3 months, and 39% among individuals diagnosed at HPS-funded community-based test sites, additional resources are needed in this area and the model for providing these services needs to be adapted. In addition to scaling up the level of effort, the linkage effort will be centralized within DPH and services will be provided by DPH staff in collaboration with community-based sites (and medical sites, where appropriate). Individuals with the most barriers to accessing and staying in care tend to have co-occurring issues, such as mental health, substance use, and homelessness, factors which disproportionately affect communities of color. The goal is that all people diagnosed with HIV in SF get the level of service and support needed to make an initial engagement with an HIV primary care provider. For some clients, this might require a more intensive effort (e.g., outreach, case management) and for others it might mean only few simple phone calls. Because the level and type of effort is tailored to the individual, and the DPH linkage and re-engagement teams will be composed of people with diverse skill sets and backgrounds, SF expects that these efforts will have the intended impact of ensuring that at least 75% of all persons diagnosed with HIV will have a CD4 count within 3 months of diagnosis, regardless of race/ethnicity.

The percent of persons receiving a CD4 count within 12 months of diagnosis is 82% of greater for all racial/ethnic groups, except the category "other/unknown" which has a 74% rate (2009 HIV/AIDS Epidemiology Annual Report). The 3-month CD4 count rate is approximately 76% citywide and 61% for HPS-funded community-based testing sites. These data justify the investment of substantial resources in this area and the centralization of the effort within DPH.

Expanded Testing Initiative Part B funds will support DPH linkage staff, complementing existing efforts at community-based HIV testing sites which will be paid for by CDC base and SF General Fund.

Appendix 1: The SF HIV/AIDS Strategy: New Approaches

Part 1: Shifts in HIV Prevention Section-Funded Services

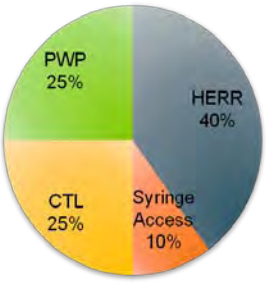
In November 2010, the HIV Prevention Section (HPS) request for proposals (RFP) #21-2010 "HIV Prevention Programs for Communities Highly affected by HIV." Funds available through the RFP come from CDC base, State of California, SF General Fund, and SAMHSA and total approximately $6,660,000. The RFP solicits services in 8 categories:

- Category 1: Community-Based HIV Testing (Addresses Intervention #2, 6, and 12)
- Category 2: Health Education/Risk Reduction (HERR) to Address Drivers among MSM, with a Focus on Gay Males (Addresses Interventions #14 and 19)
- Category 3: Prevention with Positives (PWP) (Addresses Interventions #7, 9, 10, 13, and 14)
- Category 4: Special Projects to Address HIV-Related Health Disparities Among African American MSM (Addresses Interventions #2, 3, 6, 12, and 19 and may also address #7, 9, 10, 14, 22, and 24)
- Category 5: Special Projects to Address HIV-Related Health Disparities Among Latino MSM (Addresses Interventions #2, 3, 6, 12, and 19 and may also address #7, 9, 10, 14, 22, and 24)
- Category 6: Special Projects to Address HIV-Related Health Disparities Among MSM (Addresses Interventions #2, 3, 6, 12, and 19 and may also address #7, 9, 10, 14, 22, and 24)
- Category 7: Special Projects to Address HIV-Related Health Disparities Among TFSM (Addresses Interventions #2, 3, 6, 12, and 19 and may also address #7, 9, 10, 14, 22, and 24)
- Category 8: Citywide Syringe Program (Addressed Intervention #26)

Together with DPH-delivered services, this represents both a shift in the proportion of resources devoted to various interventions, as well as a shift in intervention content.

The 2009 resource allocation by the four main interventions categories and the proposed resource allocation beginning July 1, 2011 are presented below. Increased resources will be devoted to HIV Status Awareness/Testing and fewer resources will be devoted to HERR. While PWP resources will decrease slightly, there will be an increased focus on treatment adherence and engagement in care and a decreased focus on behavioral interventions to reduce HIV risk within PWP programs.

2009



-Increase allocation to Status Awareness

-Reduce allocation to HERR

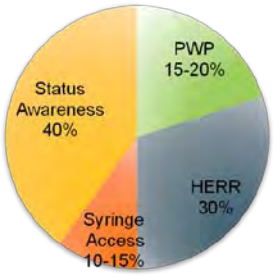
-Include testing outcomes for HERR

-Include new focus on drivers within HERR

-Shift focus of PWP activities

-Maintain/increase syringe access

Proposed starting July 1, 2011



In addition, some of the HPS's PWP funds will support PWP programs within primary care/Centers of Excellence settings. These funds were solicited within the Centers of Excellence RFP, released in October 2010 and are reflected in the PWP slice for the proposed resource allocation staring July 1, 2011.

The determination for prevention funding has not yet been made for either RFP. Information on specific agencies funded and program details will be available on or around July 1, 2011.

Part 2: New DPH-Delivered Services (Interventions #6, 7, and 12)

To supplement community-based services (Part 1), the new SFDPH Engagement and Support Efforts (EASE) Program will provide linkage to HIV primary care, partner services, and re-engagement in care services to HIV-positive individuals within San Francisco. The program is designed to provide a seamless continuum of services for people living with HIV/AIDS and to complement rather than replace existing efforts. Funding for these services is reflected in the proposed resource allocation pie chart, beginning July 1, 2011 (above). This program has two primary components:

- **Partner services and linkage, provided by the SFDPH STD Prevention and Control Section.** SFDPH will directly offer partner services and linkage to HIV primary care to clients testing HIV-positive in community-based settings. At high-volume test sites, an SFDPH staff person will work on site and operate as part of the HIV testing team. In addition, up to two "rovers" will be available to provide this service at lower volume test sites that do not diagnose sufficient new positives to warrant a full-time on-site SFDPH staff person. In addition, SFDPH will offer partner services to individuals testing HIV-positive in medical settings, both public and private. A second priority will be to offer partner services to long-term HIV-positive individuals.

- **Navigation, provided by the SFDPH HIV Prevention Section.** The navigation component of the EASE Program will complement existing efforts related to re-engagement in care. Navigation clients will be identified in four distinct ways:
    - Clients who the Linkage and Partner Services team are not able successfully link to care within 90 days of diagnosis will be referred to the navigation team.
    - The navigation team will work with SFDPH and private medical practices to identify clients who are lost to care or at risk for missing appointments, and for whom follow-up is not possible due to insufficient resources within the practice. The navigation team will then work with the HIV surveillance staff to disposition the cases (e.g., lost to care, dead, moved out of jurisdiction), and then provide navigation services to those clients lost to care.
    - The navigation team will work with HIV surveillance staff to identify the universe of clients with high viral load and conduct public health follow-up with these individuals to determine whether an intervention is needed.
    - When a client in care needs to or wishes to transition their care to another practice, the navigation team will help match-make the client with a clinic or provider that can meet their needs.

  Surveillance data shows that issues such as mental health, substance use, and homelessness are strongly correlated with being out of care and having high viral load. The navigation intake will include a thorough assessment of these and other issues and the navigation intervention will link clients to appropriate services beyond just HIV primary care.