SFDPH Application to CDC Funding Announcement PS18-1802

HIV Community Planning Council
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POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Proposal Overview

Current Focus (2010-present)

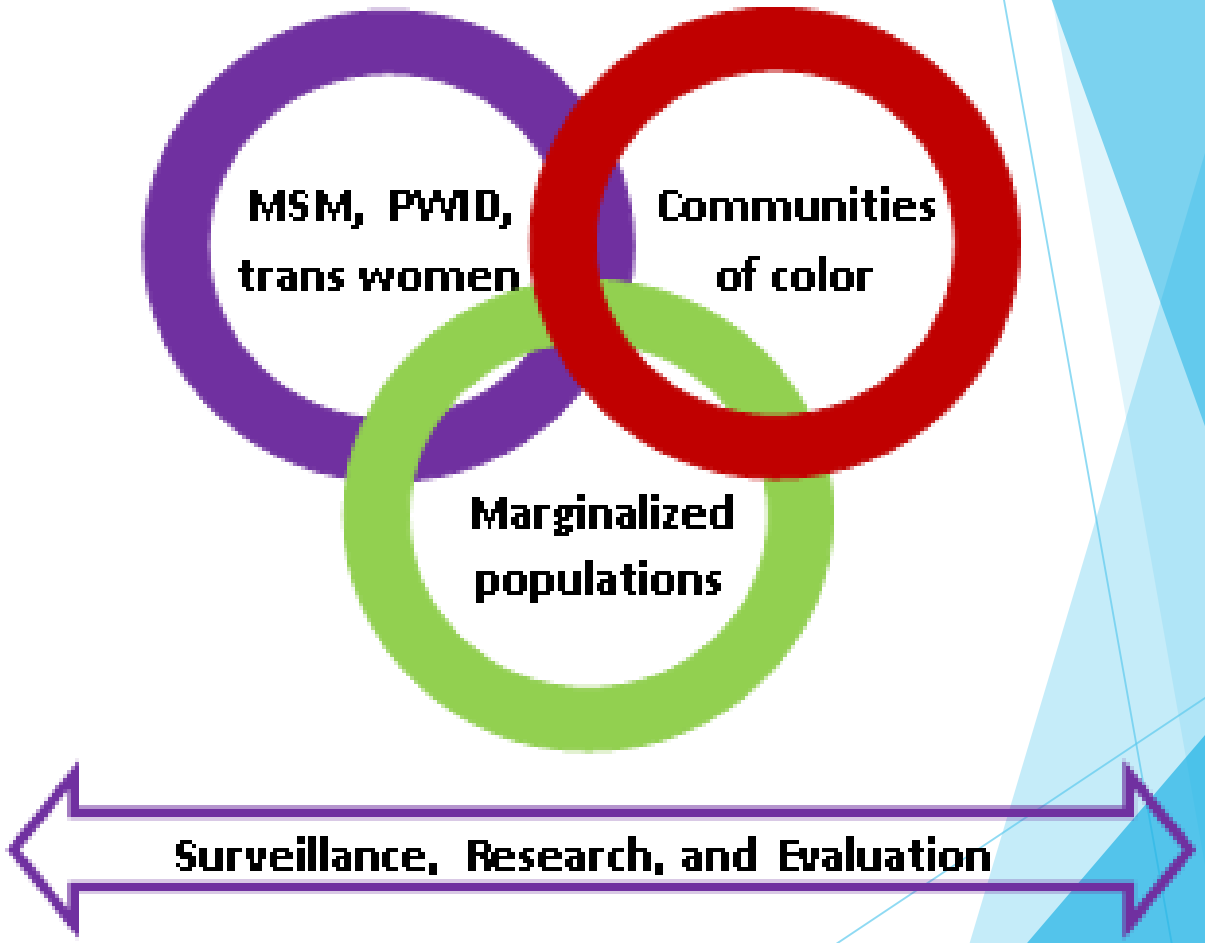
HIP* for high prevalence populations, with some programming for communities of color and marginalized populations

Proposed Focus, Component A

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

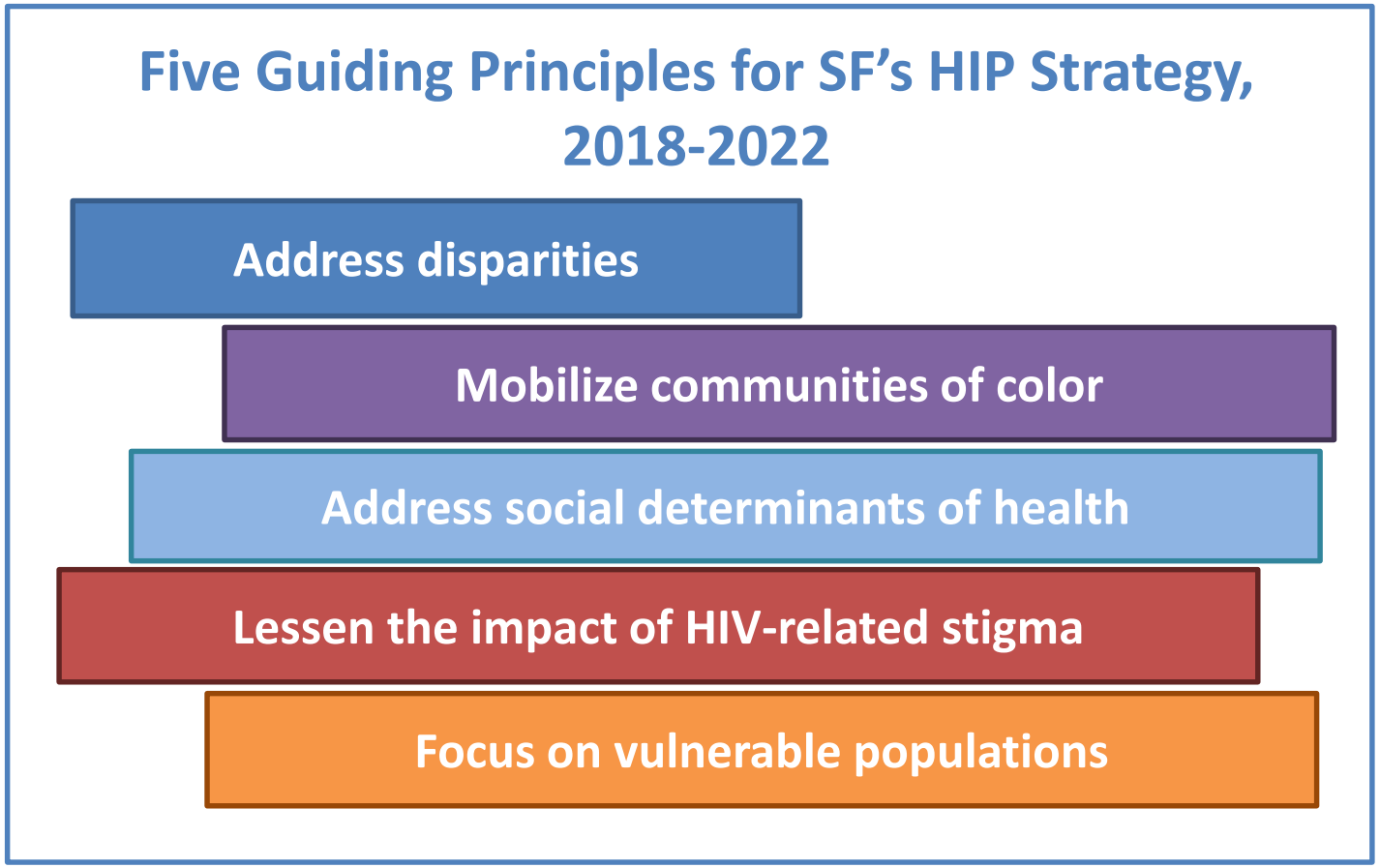
Proposed Focus, Component B

Add innovative programming to better address disparities among marginalize populations



*HIP = high impact prevention

Guiding Principles



Component A:
Core HIV Prevention & Surveillance Funding

- Continue:
  - Robust HIV surveillance system
  - High-volume community-based testing
  - Data to Care
  - LINCS (linkage, navigation, partner services)
  - Community-based and clinic-based PrEP
  - Syringe access & disposal
  - Condom distribution
  - Community planning

Component A:
Core HIV Prevention & Surveillance Funding (cont.)

- What's new/shifted:
  - Increased community engagement & mobilization in communities of color
  - Partner services offered to out-of-care PLWH
  - Better address late testing and high rates of undiagnosed HIV among PWID
  - Increased focus on sexual health and STDs
  - Focus of community-based health education risk reduction & prevention with positives activities (?)
  - Molecular surveillance required
  - Using Results-Based Accountability (RBA) for evaluation/quality improvement

Component B: Demonstration Project

This project will bring services to people for whom conventional HIP has failed to reach effectively, using ***a systems transformation approach***:

Focus Populations

- **Homeless**
- **PWID**
- **HCV-coinfected**
- **Women**
- **Incarcerated**

(and their sex & injection partners/networks)

1) Addressing systems gaps in HIV prevention and retention
2) Outreach and field-based services for homeless, marginally housed, and drug-using populations; and
3) Data to HIV Care/Data to HCV Cure (called DTC^2)

Systems Change Framework – "Whole Person Care"

Reactive/urgent/ acute care

Examples: Emergency Department, Street Medicine

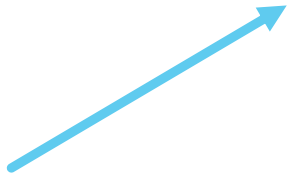
Transition & stabilization

Examples: Housing transition services, benefits enrollment

Wellness "Whole person, whole story"

Examples: Primary care, permanent supportive housing, no gaps in insurance, easy access to ART/PrEP, employment services, system that allows people to achieve their potential

This is the system we want to have



How will the demo project get us there? Strategy 1: Address prevention/retention gaps

- Boost system capacity to prevent people from falling out of care/falling off PrEP in the first place
  - Data to PrEP
  - Panel management for PLWH and people taking PrEP
  - Strengthen collaborations with jails/parole/post-release programs
  - Trauma-informed care and harm reduction training

How will the demo project get us there? Strategy 2: Homeless Outreach & Engagement

- Strengthening regular presence & trust
- Building capacity to give people what they need right there in the moment – a ride, food, entering substance use treatment that day, etc.
- Gradually moving people towards "brick & mortar" care when appropriate
- Field-based services will include:
  - Field-based HIV/HCV/STD testing
  - Directly observed HIV/HCV therapy
  - PrEP & buprenorphine prescriptions
  - Linkages to substance use treatment, housing, and other services

How will the demo project get us there? Strategy 3: DTC^2

- Locate and provide HIV and HCV treatment to out-of-care people living with HIV who also have HCV
  - We think far fewer than 500
  - Will use a data to care model to try to identify, locate, link people to treatment & support them to engage in health services long-term
  - New 8-week regimen available – better than 12 weeks for populations with multiple barriers to care
  - Does linkage to HCV navigation services improve re-engagement in HIV care for PLWH who are not-in-care?

Long-Term Project Outcomes

CDC's Outcomes

- Reduced new HIV infections among persons at risk for HIV infection
- Increased access to care for PLWH
- Improved health outcomes for PLWH
- Reduced HIV-related health disparities
- Reduced death rate among PLWH

SF's Proposed Outcomes

Reduce new HIV diagnoses by 50%, from 223 in 2016 to 111 in 2022

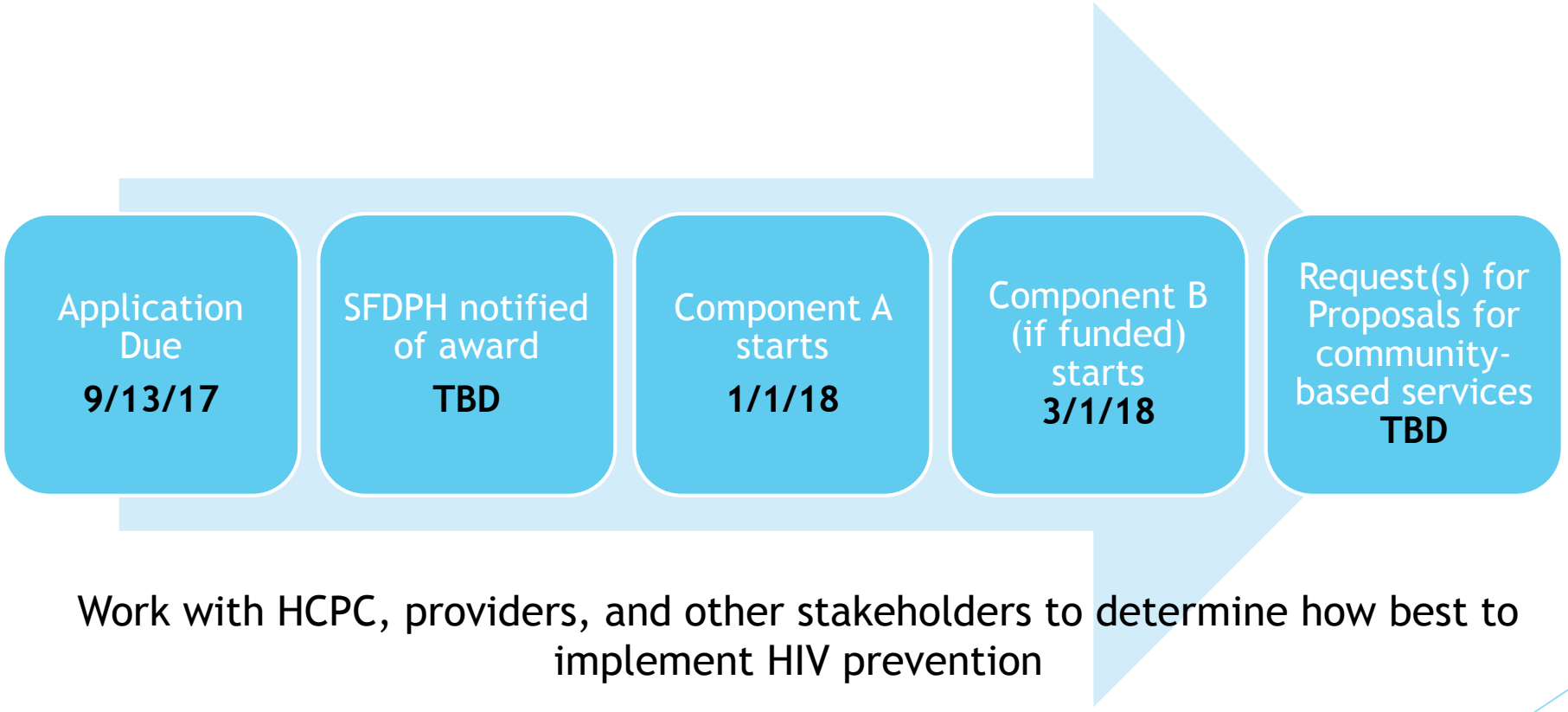
Increase the proportion of persons newly diagnosed with HIV who are inked to care within 1 month of diagnosis, from 78% in 2015 to 85% by 2022

Increase the proportion of persons newly diagnosed with HIV who achieve viral suppression within 12 months of diagnosis, from 77% in 2015 to 85% by 2022

Increase retention in care among populations retained and therefore virally suppressed (cis and trans gender women, people of color, PWID and homeless) by 5% by 2022

Reduce the HIV-related death rate among PLWH by 10%, from 15 per 1,000 in 2015 to 13 per 1,000 by 2022

Timeline & Next Steps



Work with HCPC, providers, and other stakeholders to determine how best to implement HIV prevention

Discussion, Feedback & Letter of Support

- This is “proposed” – we will work with all of you in 2018 to further refine these ideas and determine how best to implement HIV prevention
- SFDPH requests a letter of support from the HCPC for our application, both Components A and B
- **Help us name our demonstration project!**