SFDPH Application to CDC Funding Announcement PS18-1802

HIV Community Planning Council
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Tracey Packer, MPH
Director, Community Health Equity & Promotion (CHEP) Branch, SFDPH

Susan Philip, MD, MPH
Director, Disease Prevention and Control (DPC) Branch, SFDPH

Susan Scheer, PhD, MPH
Director, HIV Epidemiology Section, Applied Research, Community Health Epidemiology, & Surveillance (ARCHES) branch, SFDPH
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 marginalized populations

*HIP = high impact prevention
Five Guiding Principles for SF’s HIP Strategy, 2018-2022

- Address disparities
- Mobilize communities of color
- Address social determinants of health
- Lessen the impact of HIV-related stigma
- Focus on vulnerable populations
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
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:

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 DTC²)

Focus Populations
- Homeless
- PWID
- HCV-coinfected
- Women
- Incarcerated

(and their sex & injection partners/networks)
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: DTC²

- 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

- **Application Due**: 9/13/17
- **SFPDH notified of award**: TBD
- **Component A starts**: 1/1/18
- **Component B (if funded) starts**: 3/1/18
- **Request(s) for Proposals for community-based services**: TBD

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!