2009 - 2012 COMPREHENSIVE HIV HEALTH SERVICES PLAN

SAN FRANCISCO, CALIFORNIA ELIGIBLE METROPOLITAN AREA (EMA)

SAN FRANCISCO HIV HEALTH SERVICES PLANNING COUNCIL
&
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH, HIV HEALTH SERVICES

January 5, 2009

San Francisco, California Eligible Metropolitan Area 2009-2012 Comprehensive HIV Health Services Plan

TABLE OF CONTENTS

San Francisco HIV Health Services Planning Council

San Francisco Eligible Metropolitan Area
San Francisco, San Mateo, and Marin Counties

December 15, 2008

Douglas Morgan, MPA
Director, Division of Service Systems
HIV/AIDS Bureau, HRSA
5600 Fishers Lane, Room 7A-55
Rockville, MD 20857

Dear Mr. Morgan:

This letter serves as assurance that the San Francisco HIV Health Services Planning Council has developed and approved the Three-year Action Plan (Section 3) contained in the attached 2009-2012 Comprehensive HIV Services Plan for the San Francisco EMA.

The Planning Council strategized a process for preparing the Comprehensive Plan in meetings of the Planning Council Steering Committee and approved this process in meetings of the Council as a whole. Council members took part in activities to research and develop the Plan, culminating in a special planning meeting that brought together a wide range of Council members to review the goals, objectives, and action steps from the previous Plan and to develop a new version to guide our activities over the coming three years. In making its decisions, the Council considered its own ongoing tracking of goals and objectives in the 2006-2008 Comprehensive Plan, and received input from the Grantee agency and from representatives of the Marin and San Mateo County HIV/AIDS Programs.

The enclosed Plan offers a blueprint to guide the San Francisco HIV Health Services Planning Council throughout the term of the Plan, particularly as the Council struggles to continue providing excellent care in the face of diminishing financial resources. The Council views the Plan as a living document to help guide future discussion and decision-making, and to allow us to continue ensuring the highest possible quality of care and care access for severe need, underserved, and disadvantaged HIV-infected individuals in our region.

Sincerely,

Steve Manley
Co-Chair

Mark Molnar
Co-Chair

Laura Thomas
Co-Chair

415-674-4768 730 Polk Street, 3rd Floor, San Francisco CA 94109 415-674-0373 fax
www.sfcarecouncil.org

CONTRIBUTORS / ACKNOWLEDGMENTS

The San Francisco HIV Health Services Planning Council worked in close collaboration with the Ryan White Programs Part A Grantee agency - the San Francisco Department of Public Health, HIV Health Services - to develop this Comprehensive Plan. We are grateful to all those who contributed to the process of Plan development and approval.

San Francisco HIV Health Services Planning Council Members

Randy Allgaier*
John L. Andrews*
Margot Antonetty*
Raymond Banks
Noah Anthony Briones
Billie J. Cooper
Wade Flores
Donald Frazier*
Chris Harris
Kelly Rivera Hart*
Maritza Penagos*
Anna Dowling Heath
Mary Lawrence Hicks*
Ronald Lee Jewell*
Johnson Livingston
Marcus L. Mabry*
Steve Manley (Co-Chair)*
Paul Margolis
Mark Molnar (Co-Chair)*
Catherine Newell
Ken Pearce
Susan Philip*
Veronica Pillatzke
Geraldo Ramos
Stacia Anne Scherich
George Simmons
Charles Siron
Donald Soto*
Ellen Sweetin
Sparkie Spaeth
Laura Thomas (Co-Chair)*

* Denotes Steering Committee member

San Francisco HIV Health Services Staff

Michelle Long, M.H.A., Director, HIV Health Services

Francine Austin
Bill Blum
Celinda Cantu
Joseph Cecere
Dean Goodwin
Christopher Gortner
Cara Guevara
Proceso Hernandez
Marshia Herring
Marguerite Heyward
Hilda Jones
Herman Levias
Maria Lacayo
David Macias
Flor Roman

Key support for the planning process was provided by Planning Council staff based at Shanti, including Greg Zhovreboff, T.J. Lee, and Natalie Bryson. Robert Whirry, an independent Program Development Consultant, worked with HIV Health Services and the HIV Health Services Planning Council to organize the planning process and to draft and revise the text of the Comprehensive Plan.

INTRODUCTION

Three years ago, in 2005, the San Francisco EMA conducted a large-scale, six-month process designed to produce a new three-year Comprehensive Plan for HIV Services that would provide a roadmap to guide the region in the continued development, refinement, and modification of our model continuum of HIV/AIDS care. The 2006-2009 Plan contained a series of goals and objectives for enhancing HIV care provision, care access, and program monitoring, along with a series of staged action steps describing specific activities to attain the Plan's objectives. The Plan was produced through a collaborative process involving the San Francisco HIV Health Services Planning Council, San Francisco HIV Health Services, and representatives of the San Mateo and Marin County HIV programs.

Since the time of the Plan's development, our EMA has confronted significant challenges that have complicated the task of attaining some of the objectives and action steps described in the Plan. While continually striving to enhance and improve the system of care through a number of key innovations and initiatives - most notably involving implementation of the EMA's new Centers of Excellence program - our region has also continued to cope with rapidly expanding HIV caseloads in face of diminished HIV resources. Nevertheless, the three-year Plan has continued to serve as a highly effective framework for guiding our efforts to bring about key systemic enhancements that have greatly increased our capacity to serve high need populations in our region, while expanding our success at bringing into and retaining in care an increasingly complex service population. The Plan has also pointed the way to effective enhancements in our region's program monitoring and quality management activities that have worked to the benefit of our region's Part A-eligible populations.

Because of this success, we made the decision early in the Plan development process to structure our new 2009 - 2012 Comprehensive Plan as an **updated version** of the previous Plan, rather than as an entirely new Plan document. Under this approach, the Council made the decision to prioritize the task of re-examining and restructuring the **Three-Year Action Plan** which serves as the heart of the document in Section 3, while performing relatively minor updates of the sections describing the HIV epidemiology and HIV service continuum for the region. This decision later proved to be opportune in light of the intense demands being placed on the Planning Council in late 2008, which reduced the time that would have been available for an extensive planning process.

In order to update the Three-Year Action Plan specifically, the Planning Council agreed on the structure of a **half-day planning retreat** involving a broad range of Council members, including a significant number of unaffiliated consumers. The retreat was held on **Friday, November 14, 2008** at the offices of the San Francisco Redevelopment Agency. A total of **12** Planning Council members attended the meeting, along with Planning Council staff and a representative of San Francisco HIV Health Services. In preparation for the retreat , staff of San Francisco HIV Health Services had reviewed the previous Three-Year Action Plan and provided input and suggestions, as had staff of both the Marin County and San Mateo County HIV programs. The input of these three groups was incorporated into the

retreat's proceedings. Participants in the retreat were successful in reviewing, updating, and amending the entire previous Action Plan, and made several significant changes that reflected the EMA's experience in implementing and monitoring its Centers of Excellence program, and its ongoing efforts to move toward outcomes-based, client-level data collection and monitoring. The 2009-2012 Three-Year Action Plan was approved by the Planning Council Steering Committee at its meeting of **Monday, December 15, 2008.**

The 2009-2012 Comprehensive Plan document represents an important milestone in the San Francisco EMA's continuing efforts to ensure a comprehensive continuum of HIV services that is responsive, culturally competent, and capable of serving the highest need HIV-infected populations in our region. The Council will utilize the Plan as a blueprint to guide its ongoing values and service development activities, while continually assessing progress made toward Plan objectives and action steps. The Plan will also continue to serve as a living document which will be revised, updated, and amended in order to respond to changes in the HIV epidemic and to shifts - both anticipated and unanticipated - in the fiscal, organizational, and political environment shaping the system of HIV care services for the most highly disadvantaged populations in our region.

EXECUTIVE SUMMARY

The 2009-2012 San Francisco EMA Comprehensive HIV Services Plan attempts to effectively address the ongoing crisis of HIV and AIDS in the San Francisco, California EMA – a three-county region which since the beginning of the HIV epidemic has been one of the nation's hardest hit AIDS epicenters. As of July 31, 2008, a total of **31,591** cumulative AIDS cases had been diagnosed in the EMA, representing **21%** of all AIDS cases ever diagnosed in the state of California. A total of **11,330** persons were living with AIDS as of December 31, 2007, while another **12,464** individuals were estimated to be living with HIV, for a total of **23,794** persons living with HIV infection in the three-county region as of the end of 2007. A total of **944** new cases of AIDS were diagnosed in the EMA between January 1, 2006 and December 31, 2007 alone. The city and county of San Francisco continue to have the nation's highest per capita prevalence of cumulative AIDS cases and AIDS remains the leading cause of death among male residents age 25-54. As of the end of 2007, an estimated **20,622** San Franciscans were living with AIDS or HIV, for a staggering citywide prevalence of **2,771** cases of HIV per 100,000, meaning that **1 in every 36** San Franciscans is living with HIV disease

Ensuring a seamless, comprehensive, accessible, and culturally competent continuum of care for this large and highly concentrated HIV-infected population is complicated by the increasing range of **co-morbidities** affecting local persons with HIV, and by the large number of impoverished, multiply diagnosed, and severe need populations in our region. For example, **sixty-two percent** of persons living with HIV and AIDS and **one hundred percent** of persons in the Ryan White system are living at or below 300% of federal poverty level. **Twenty-five percent** of persons with HIV have no form of health insurance. **Nearly one in ten** persons newly diagnosed with AIDS in the EMA are homeless. As many as **half** of MSM living with HIV in the EMA suffer from depression. **Thirty percent** of local PLWHA are active substance users. **One in seven** persons with HIV in the EMA speaks a primary language other than English. **As many as one-third** of gay-identified men in the San Francisco EMA may be HIV-infected. **Thirty-five percent** or more of transgender persons are believed to be HIV-infected, including **over half** of all African American male-to-female transgender persons. And these are only a few examples.

The San Francisco EMA has a long and distinguished history of responding to this daunting crisis with programs and systems that are impactful, innovative, sensitive, cost-effective, and above all, client-centered. The recent implementation of our innovative and aggressive **HIV Centers of Excellence program** designed to better and more cost-effectively serve severe need populations is only one example of how our EMA continues to provide national leadership in the development of effective HIV service approaches. In order to continue to provide this same high level of leadership in an environment of diminishing resources and increasing need, our 2009-2012 Comprehensive Plan proposes a complex and assertive **three-year action plan** which details an integrated set of goals, objectives, and action steps to guide the work of our EMA in planning and implementing an effective system of HIV care over the coming years. This action plan includes components designed to increase service access and ensure parity of care; to enhance data collection

and cost-effectively distribute resources; to increase service collaboration and integration; and to reach, bring into, and retain in care a wide range of difficult-to-reach populations. The Plan also proposes a detailed evaluation process to ensure ongoing monitoring of all Plan objectives and activities, and to allow for the continual modification and enhancement of the Plan throughout its history.

Our action plan also includes a range of new activities designed to increase our understanding of the nature and needs of local HIV-infected populations, and to continually improve the way in which we plan, develop, and monitor services. For example, Objective # 3.3. describes a plan to conduct small-scale, focused annual needs assessments related to specific populations and care issues during years in which a full-scale EMA-wide needs assessment is not taking place, while Objective # 2.2. describes a series of steps to enhance the quality and accuracy of data collection and reporting in the EMA. The Plan prioritizes services and service planning to meet the needs of complex, underserved, and emerging populations, including Goal # 4 , focused on out of care populations; Goal # 5, focused on persons of color; Goal # 6, centering around the needs of women and transgender persons; and Goal # 7, focused on persons living with HIV and AIDS who are 50 years of age and older. The Plan also proposes several significant enhancements to the EMA's Clinical Quality Management program, including implementation of expanded outcomes-based evaluation described in Objective # 10.1.

As noted in the preceding Introduction, it is our hope that the 2009-2012 Comprehensive HIV Health Services Plan will serve as a living document to guide our EMA in the continued development of an effective continuum of care which seeks to reach and serve all impoverished, underserved, multiply diagnosed, and special needs populations in our region. At the same time, however, our Plan recognizes the increasing difficulty our EMA is likely to face in attempting to provide services for a growing and increasingly complex HIV-infected population in the face of decreased funding and potentially decreased support for services that are essential for bringing and retaining high-need populations in care. While we are committed to making whatever difficult decisions are needed to ensure the effective utilization of Ryan White funds, it is our ardent hope that such decisions will not necessitate the removal from care of men, women, and children with HIV/AIDS who are in desperate need of the publicly funded treatment and support services which the Ryan White Act currently makes possible.

SECTION 1: WHERE ARE WE NOW: WHAT IS OUR CURRENT SYSTEM OF CARE?

A. DESCRIPTION OF THE ELIGIBLE METROPOLITAN AREA

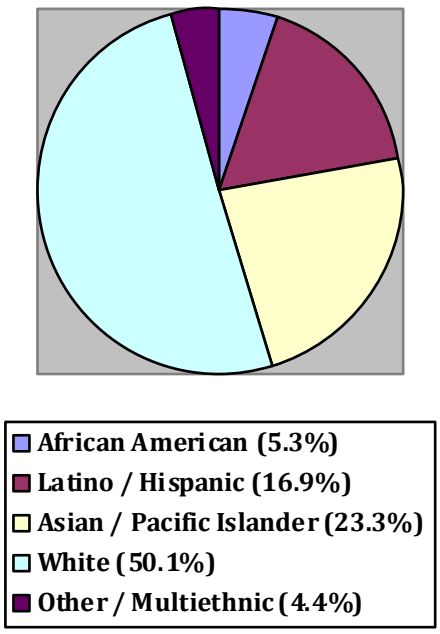
Located along the western edge of the San Francisco Bay in Northern California, the San Francisco EMA is a unique, diverse, and highly complex region in terms of both geography and the nature and distribution of its people. Encompassing three distinct counties - **Marin County** in the north, **San Francisco County** in the center, and **San Mateo County** in the south - the EMA has a total land area of **1,016** square miles, an area roughly the size of Rhode Island. In geographic terms, the EMA is very narrow, stretching more than 75 miles from its northern to southern ends, but with a distance of less than 20 miles at its widest point from east to west. This complicates transportation and service access in the region, especially for those in Marin and San Mateo Counties. In San Mateo County, a mountain range marking the western boundary of the San Andreas Fault bisects the region from north to south, creating further challenges for those attempting to move between the county's eastern and western sides.

The San Francisco EMA is unusual in part because of the dramatic difference in size among its three member counties. While Marin and San Mateo Counties encompass a total land area of **520** and **449** square miles, respectively, San Francisco County covers an area of only **47** square miles, making it by far the **smallest county in California** geographically, and the **sixth smallest county in the US** in terms of total land area. San Francisco is also one of only three major cities in the US (the others are Denver, Colorado and Washington, DC) in which the city's borders are identical to those of the county in which it is located. In San Francisco, the unification of city and county governments under a single mayor and a Board of Supervisors functioning in the manner of a City Council allows for a more streamlined service planning and delivery process, creating economies of scale that to some degree offset the high cost of doing business in the region.

The total 2006 population of the San Francisco EMA was estimated by the US Census Bureau at **1,698,282**.[1] This includes a population of **248,742** in Marin County, **744,041** in San Francisco County, and **705,499** in San Mateo County, with widely varying population densities within the three regions. While the population density of Marin County is **479** persons per square mile, for example, the density of San Francisco County is a stunning **15,936 persons per square mile** - the highest population density of any county in the nation outside of New York City. While San Mateo County lies between these two extremes, its density of **1,571** persons per square mile is still ten times lower than its neighbor county to the north. These differences necessitate widely varying approaches to HIV care within the three counties of the EMA.

The geographic diversity of the San Francisco EMA is reflected in the diversity of the people who call the area home. Just under **50%** of the EMA's residents are persons of color, including large Asian/Pacific Islander (**23.3%**), Latino (**16.9%**), African American (**5.3%**), and Native American (**0.4%**) populations (see Figure 1). The nation's largest population of Chinese Americans lives in the City of San Francisco, joined by a diverse range of Asian immigrants, including large numbers of Japanese, Vietnamese, Laotian, and Cambodian residents; in San Francisco, Asian residents make up over **30%** of the city's total population. A large number of Latino immigrants also reside in the EMA, including native residents of Mexico, Guatemala, El Salvador, and Nicaragua. EMA-wide, over **40%** of residents speak a language other than English at home - including **46%** of San Francisco residents[2] - with over **100** separate Asian dialects alone spoken in the city. Only **half** of the high school students in the City of San Francisco were born in the United States, and almost **one-quarter** have been in the country six years or less.[3] A total of over **20,000** new immigrants join the EMA's population each year, not including as many as **75,000** permanent and semi-permanent undocumented residents.[4]

Figure 1. Ethnic Compsition of the San Francisco EMA, 2006

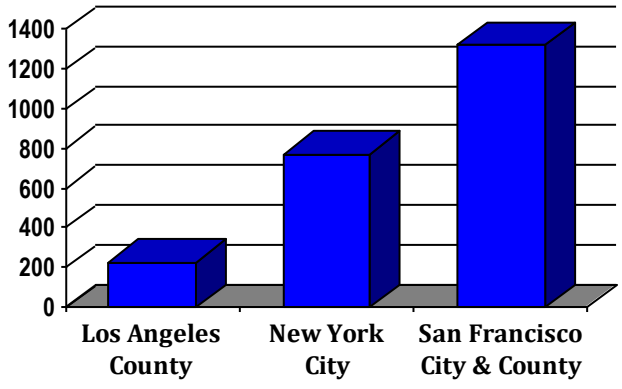


B. EPIDEMIOLOGICAL PROFILE

More than a quarter century into the HIV epidemic, the three counties of the San Francisco EMA continue to be devastated by the crisis of HIV – a continuing tragedy that has exacted an incalculable human and financial toll on our region. According to the State of California, as of July 31, 2008, **31,591** cumulative AIDS cases had been diagnosed in the EMA, representing **21%** of all AIDS cases ever diagnosed in the state of California (n=**150,494**).[5] Just under **21,000** persons have already died of AIDS in the EMA.[6] Combined data for the EMA's three counties indicates that **11,330** persons were living with AIDS as of December 31, 2007, while another **12,464** individuals were estimated to be living with HIV, for a total of **23,794** persons living with HIV infection in the three-county region as of the end of 2007 (see Attachment 3).[7] This represents an EMA-wide HIV infection incidence of **1,401.1** cases per 100,000 persons, meaning that **more than 1 in every 71 residents of the San Francisco EMA is now living with HIV.** A total of **944** new cases of AIDS were diagnosed in the EMA between January 1, 2006 and December 31, 2007 alone, representing **8.3%** of all persons living with AIDS at the end of 2007.

At the epicenter of this crisis lies the city and county of San Francisco, the city hardest-hit during the initial years of the AIDS epidemic. **Today, the city of San Francisco continues to have the nation's highest per capita prevalence of cumulative AIDS cases,[8] and AIDS remains the leading cause of death among male residents age 25-54.[9]** The number of persons living with AIDS in San Francisco has increased by **43%** over the last decade alone - a percentage that does not include non-AIDS HIV cases.[10] Through December 31, 2007, a cumulative total of **27,592** cases of AIDS had been diagnosed in San Francisco, accounting for nearly **3%** of all AIDS cases ever identified in the US (n=**992,865**) and nearly **20%** of all AIDS cases diagnosed in California (n=**147,821**), despite the fact that the county contains only **2%** of the state's population.[11] As of the end of 2007, an estimated **20,622** San Franciscans were living with AIDS or HIV, representing **87%** of all persons living with HIV/AIDS in the EMA, for a staggering citywide prevalence of **2,771** cases of HIV per 100,000. **This means that 1 in every 36 San Francisco residents is living with HIV disease - an astonishing concentration of HIV infection in a city with a population of only 744,000.** As of July – December 2007, the incidence of persons living with AIDS per 100,000 in San Francisco County (**1,319.8** per 100,000) was over **five times** that of Los Angeles County (**225.7** per 100,000) and **nearly double** that of New York City (**771.1** per 100,000) (see Figure 2).[12] The following sections describe the demographics of the local epidemic.

Figure 2. People Living with AIDS Per 100,000 Population as of 12/31/07 - Selected US Metropolitan Areas



- ***Race / Ethnicity:*** Reflecting the ethnic diversity of our EMA, the region's HIV/AIDS caseload is distributed among a wide range of ethnic groups. The majority of persons with HIV and AIDS in the EMA are white (**62.9%**), with an additional **15.0%** of cases among African Americans; **15.3%** among Latinos; and **4.7%** among Asian / Pacific Islander groups (see Figure 3). A total of **4,114** persons of color were living with AIDS in the San Francisco EMA as of December 31, 2007, representing **36.3%** of all PLWA, while another **4,707** persons of color were estimated to be living with HIV as of the same date (**36.2%** of all PLWHA), for a total of **8,821** persons of color living with HIV/AIDS. **However, the percentage of new AIDS cases among persons of color is increasing rapidly.** While **36.3%** of all people living with AIDS as of December 31, 2007 were persons of color (n=**4,114**), **43.5%** of new AIDS cases diagnosed between January 1, 2006 and December 31, 2007 were among persons of color (n=**411**). The disproportionate representation of HIV infection among African Americans is most dramatic among **women**, with African American women making up **40.7%** of all women living with HIV/AIDS in the EMA. In San Francisco alone, African American women make up **43.6%** of all women living with AIDS as of December 31, 2007 and **50.8%** of all women newly diagnosed with AIDS between January 1, 2006 and December 31, 2007, while constituting only **8%** of the city's total female population.

Figure 3. Ethnicity of People Living with AIDS in the San Francisco EMA as of December 31, 2007

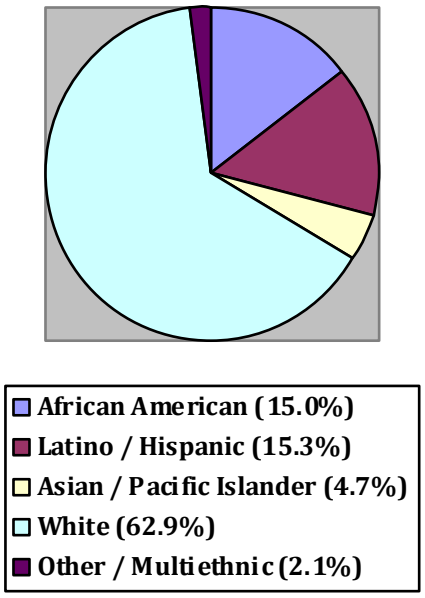
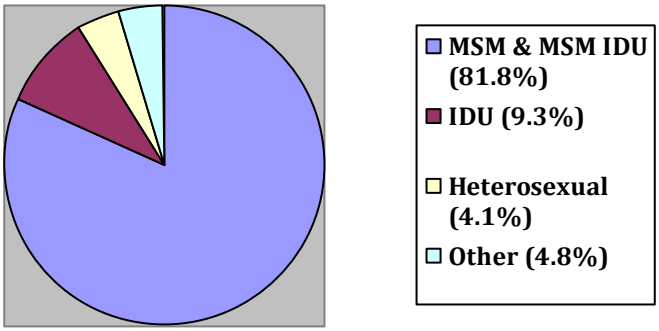


Figure 4. HIV Transmission Categories of San Francisco EMA Combined PLWA / PLWH Population as of December 31, 2007



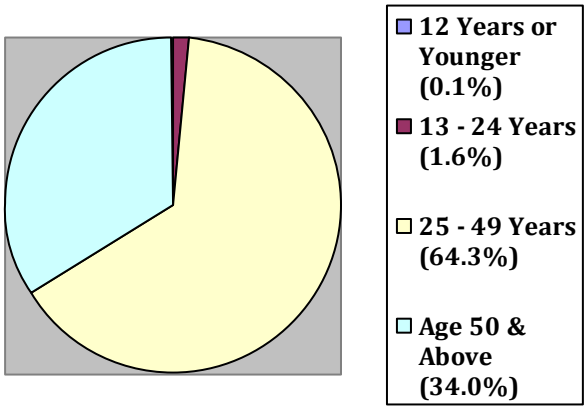
- ***Transmission Categories:*** **The most important distinguishing characteristic of the HIV epidemic in the San Francisco EMA involves the fact that HIV remains primarily a disease of men who have sex with men**

(MSM). In other regions of the US, the impact on MSM has declined over time as other populations such as injection drug users and heterosexuals have been hard-hit by the epidemic. While these groups have been severely impacted in our region as well, their representation as a proportion of total persons living with HIV and AIDS (PLWHA) has not been as high. Through December 31, 2007, fully **81.8%** of the population of persons living with HIV/AIDS in our region were MSM (**19,458**), including **16,636** men infected with HIV through MSM contact only (**69.9%** of all PLWHA) and **2,822** MSM who also injected drugs (**11.9%** of all PLWHA) (see Figure 4). By comparison, only **30.3%** of PLWHA in New York City as of June 30, 2007 were listed as infected through MSM contact.[13] Factors underlying this difference include the high proportion of gay and bisexual men living in our EMA, and the fact that many gay and bisexual men move to San Francisco to receive HIV care and treatment. Other significant transmission categories include injection drug users (**9.3%** of PLWHA) and non-IDU heterosexuals (**4.1%**). There are signs that this latter population may be increasingly rapidly, however, with **6.8%** of new AIDS cases diagnosed between January 1, 2006 and December 31, 2007 occurring among non-drug-using heterosexuals (n=**64**).

- ***Gender:*** Reflecting the high prevalence of HIV/AIDS among men who have sex with men, the vast majority of those living with HIV and AIDS in the San Francisco EMA (**91.0%**) are men. **7%** of all PLWHA in the region are women - over **two-thirds** of them (**67.3%**) of them women of color. However, the proportion of women with AIDS in the EMA is steadily increasing, constituting **7.5%** of new AIDS cases diagnosed among women between January 1, 2006 and December 31, 2007. Because of their high representation within the San Francisco population, **transgender persons** also make up a significant percentage of PLWHA, with at least **473** transgender individuals - the vast majority of them male-to-female – estimated to be living with HIV or AIDS in the EMA as of December 31, 2007, a figure representing **2.0%** of the region's PLWHA caseload.[14]

- ***Current Age:***[15] **An increasingly high proportion of persons living with HIV and AIDS in our region are age 50 and above.** This is attributable both to the long history of the HIV/AIDS epidemic in our EMA, resulting in a large proportion of long-term survivors, and our region's hard-fought success in bringing persons with HIV into care and helping them remain on medications, a success that has significantly lengthened the lifespan of many persons with HIV. Among the EMA's combined PLWHA population as of December 31, 2007, **over one-third** (**34.0%**) are age 50 or older, including

Figure 5. Age of San Francisco EMA Combined PLWA / PLWH Population as of December 31, 2006



at least **283** PLWHA **age 70 and older** (see Figure 5). Among persons living with AIDS, the percentage of persons 50 and older is even higher, at a dramatic **41.8%**, meaning that more than **two in every five persons living with AIDS in our EMA is age 50 or older.** Between December 2006 and December 2007 alone, the number of persons 50 and over living with AIDS increased by **7.9%** within the EMA, while the overall number of PLWA increased by only **2.2%**. This growing aging population creates new and unique challenges for the HIV service system, including the need to develop systems to coordinate and integrate HIV and geriatric care. The largest proportion of persons living with HIV and AIDS in the EMA remain between the ages of 25 and 49, who make up **64.3%** of the combined PLWHA population, and **76.3%** of new AIDS diagnoses between January 1, 2006 and December 31, 2007. A total of **377** young people 13-24 are living with HIV/AIDS, constituting **1.6%** of the EMA's PLWHA population. Only **29** children under 13 are living with HIV or AIDS in the EMA, and **no** new AIDS cases was diagnosed among this group between January 1, 2006 and December 31, 2007.

Figure 6.
Comparison of Ethnicity of Persons Living with HIV/AIDS with General EMA Population

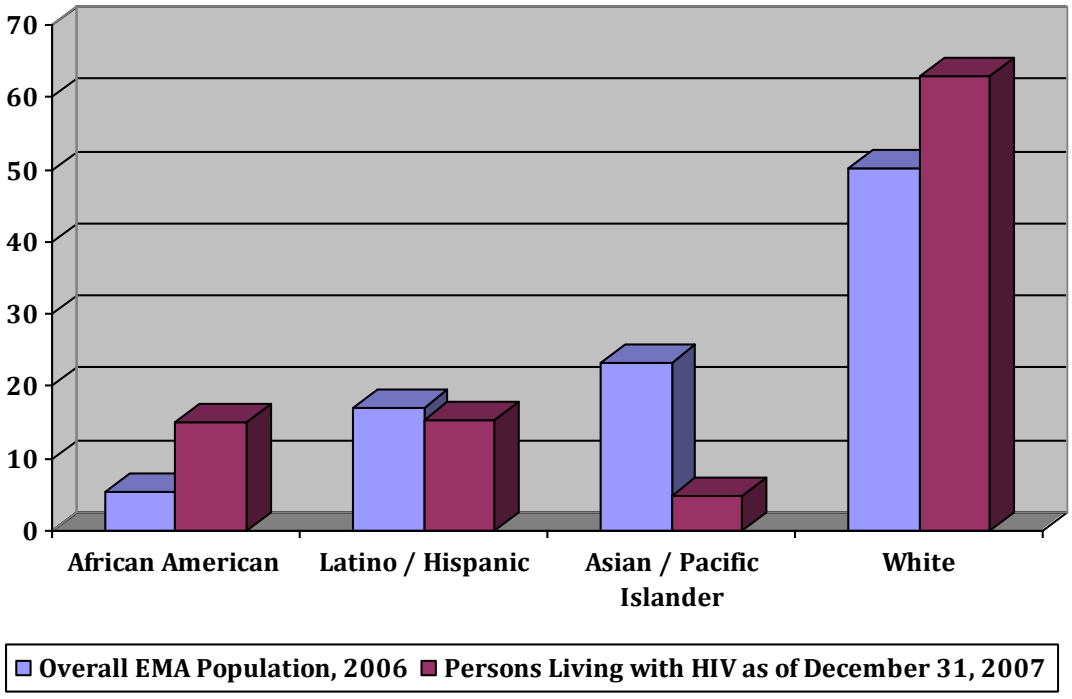


Figure 7. San Francisco EMA FY 2009 HIV and AIDS Incidence and Prevalence Summary Table									
Group / Exposure Category		**New Diagnosed AIDS Cases - 1/1/06 - 12/31/07***		**People Living with AIDS as of 12/31/07***		**People Living with HIV (not AIDS) as of 12/31/07****		**Combined Living with HIV & AIDS as of 12/31/07**	
Race/Ethnicity	African American	174	18.4%	1700	15.0%	1868	14.1%	3568	15.0%
	Latino / Hispanic	161	17.1%	1789	15.8%	1849	13.8%	3638	15.3%
	Asian / Pacific Islander	59	6.3%	532	4.7%	580	4.7%	1112	4.7%
	White (not Hispanic)	533	56.5%	7216	63.7%	7758	63.8%	14974	62.9%
	Other / Multiethnic / Unknown	17	1.8%	93	0.8%	409	3.6%	502	2.1%
Gender	Female	71	7.5%	749	6.6%	918	6.5%	1667	7.0%
	Male	844	89.4%	10358	91.4%	11296	91.4%	21654	91.0%
	Transgender	29	3.1%	223	2.0%	250	2.1%	473	2.0%
Age***	12 Years or Younger	0	0.0%	12	0.1%	17	0.1%	29	0.1%
	13 - 17 Years	1	0.1%	8	0.1%	14	0.1%	22	0.1%
	18 - 24 Years	34	3.6%	57	0.5%	293	2.4%	350	1.5%
	25 - 29 Years	75	7.9%	175	1.5%	736	6.2%	911	3.8%
	30 - 39 Years	284	30.1%	1578	13.9%	3190	26.8%	4768	20.0%
	40 - 49 Years	362	38.3%	4772	42.1%	4860	39.1%	9632	40.5%
	50 - 59 Years	140	14.8%	3568	31.5%	2597	19.6%	6165	25.9%
	60 - 69 Years	41	4.3%	994	8.8%	640	4.8%	1634	6.9%
	70 - 79 Years	6	0.6%	149	1.3%	95	0.8%	244	1.0%
	80 and Above	1	0.1%	17	0.2%	22	0.1%	39	0.2%
Transmission Categories									
Men who Have Sex with Men (MSM)		597	63.2%	7963	70.3%	8673	72.4%	16636	69.9%
Injection Drug Users		100	10.6%	1155	10.2%	1055	7.0%	2210	9.3%
MSM Who Inject Drugs		144	15.3%	1492	13.2%	1330	11.0%	2822	11.9%
Non-Injection Drug-Using Heterosexuals		64	6.8%	440	3.9%	541	3.0%	981	4.1%
Adult Other		1	0.1%	59	0.5%	37	0.2%	96	0.4%
Adult Risk Not Reported or Identified		38	4.0%	194	1.7%	795	6.3%	989	4.2%
Mother with or at Risk for HIV (Pediatric)		0	0.0%	25	0.2%	31	0.2%	56	0.2%
Pediatric Other		0	0.0%	2	0.0%	2	0.1%	4	0.0%
TOTAL		**944**	**100%**	**11330**	**100%**	**12464**	**100%**	**23794**	**100%**

*Data in this table includes individuals who are **not yet aware** of their HIV status **and** individuals who have been diagnosed with HIV and AIDS at San Quentin Prison in Marin County.

Numbers of PLWH based on an assumption of a **1-to-1.1 ratio of PLWA to PLWH based on consensus estimates obtained in the City of San Francisco between June 2005 and April 2006.

***Throughout table, age for newly diagnosed is **age at diagnosis,** while age for people living with AIDS or HIV is **age as of 12/31/07**

C. PROFILE OF EMERGING POPULATIONS

As a region with a high degree of diversity and complexity in which new cases of HIV continue to proliferate, the San Francisco EMA is home to a wide range of populations with emerging needs, including women, youth, and transgender people; members of distinct ethnic, cultural, and linguistic groups; homeless and formerly incarcerated persons; and members of diverse social and behavioral communities. These groups require specialized interventions in order to involve and retain individuals in care; meet their service needs; and empower them to become their own best care self-advocates. **The challenge of effectively meeting the needs of emerging populations in the context of declining resources and a shrinking network of providers remains one of the most daunting issues facing our system of care.** This year, we have selected the following **six** emerging populations that face evolving needs for specialized HIV care, each of which is described briefly below: **1)** Persons with HIV Over 50 Years of Age; **2)** Transgender Persons; **3)** Men of color who have sex with men; **4)** Homeless individuals; **5)** African Americans; and **6)** Latinos. All of these groups have growing incidences of HIV infection, resulting in increased costs to the local system of care.

Figure 8.
Persons Living with Diagnosed HIV or AIDS Age 50 and Above in San Francisco as of 12/31/06

Demographic Categories	Number	Percent
Gender		
Male	4,956	93.5%
Female	287	5.4%
Transgender	57	1.1%
Current Age		
50 – 54 Years	2,479	46.8%
55 – 59 Years	1,572	29.7%
60 – 64 Years	778	14.7%
65 – 69 Years	282	5.3%
70 – 74 Years	122	2.3%
75 – 79 Years	50	0.9%
Age 80 and Above	17	0.3%
Ethnicity		
White	3,735	70.5%
African American	849	16.0%
Latino	491	9.3%
Asian / Pacific Islander	161	3.0%
Other / Unknown	64	1.2%
Transmission Categories		
MSM	3,990	75.3%
Injection Drug Users	521	9.8%
MSM Injection Drug Users	524	9.9%
Non-IDU Heterosexuals	98	1.8%
Other / Unidentified	167	3.2%
TOTAL	**5,300**	**100.0%**

Emerging Population # 1: Persons With HIV Over 50 Years of Age: In part because it was one of the regions hardest hit by the HIV crisis in the early 1980s, and in part because of our success in ensuring that a large proportion of persons with HIV have access to the high quality treatments and therapies, the HIV-infected population of the San Francisco EMA continues to age dramatically, at levels beyond which could have been imagined in the first decade of the epidemic. **As of December 31, 2007, over one-third (34.0%) of all those living with HIV and AIDS in the San Francisco EMA were 50**

years of age and over (8,082 persons), including an incredible 41.8% of all persons living with AIDS in the EMA (4,728 out of 11,330 individuals) – more than two out of every five persons living with AIDS in our region.[16] An analysis conducted of the **5,300** persons age 50 and above living with diagnosed and reported AIDS and HIV as of December 31, 2006 (see Figure 8) revealed many startling facts about this population, including the fact that there are **17 persons age 80 and above** living with HIV in the EMA, along with **172** HIV-infected individuals **between the ages of 70 and 79** living with the virus. The 50+ population at this time also contained a slightly higher percentage of African Americans than in the PLWHA population as a whole (**16.0%** vs. **14.8%**), along with a slightly lower percentage of women (**5.4%** vs. **7.1%**). Because HIV medications are still relatively new, we do not yet know what the long-term effects of long-term therapy use will be on older persons with HIV, nor do we know how traditional health issues related to aging and geriatric health may interact with or complicate HIV treatment and care. Aging populations will certainly present challenges to the health care system in terms of devising new strategies for providing integrated HIV and geriatric care, and for meeting the long-term needs of clients with increasingly complex support needs. The annual **cost** of providing HIV-related services to persons over 50 years of age is estimated to be as high as **$129,320,000**.[17]

Emerging Population # 2: Transgender Persons: Transgender persons are traditionally defined as those whose gender identity, expression, or behavior is not traditionally associated with their birth sex. Some transgender individuals experience gender identity as being incongruent with their anatomical sex and may seek some degree of sexual reassignment surgery, take hormones, or undergo other cosmetic procedures. Others may pursue gender expression (whether masculine or feminine) through external self-presentation and behaviors. Key HIV risk behaviors among transgender persons include **multiple sex partners**, **irregular condom use**, and **unsafe injection practices** stemming both from drug use and from the injection of hormones and silicone.[18] Because of our region's traditional openness to diverse lifestyles, many transgender individuals move to the San Francisco EMA seeking greater acceptance and an expanded sense of community. According to Clements, at least **5,000** transgender persons call the Bay Area home, although precise statistics are not available.[19] What is not in question, however, is the epidemic's growing impact on these populations. As of December 31, 2007, at least **438** transgender persons were living with HIV and AIDS in the City of San Francisco, with another **26** living in Marin County (the County of San Mateo does not break out transgender HIV cases separately). The actual numbers, however, are probably much higher, with some studies indicating that HIV infection rates may be as high as **23.8%** among this population**,** which in San Francisco would mean that at least **1,200** transgender persons may already be living with HIV.[20] In San Francisco, transgender persons with HIV are overwhelmingly categorized as having been infected through MSM sexual contact (**97.2%**), although many MTF clients living with HIV have undergone sexual reassignment surgery and are now women. Reflecting high rates of unsafe injection practices within this population, **45.2%** of local transgender PLWHA were infected through MSM contact **and** unsafe injection practices, a percentage **32.9% higher** than among all PLWHA. Persons of

color make up nearly **two-thirds** of all transgender PLWHA in San Francisco, with African Americans constituting **38.0%** of transgender PLWHA and Latinos making up another **24.6%**, The San Francisco transgender population is also young, with persons between the ages of 18 and 29 making up **36%** of all AIDS cases diagnosed between January 1, 2006 and December 1, 2007. Because of their variance from accepted norms, transgender persons face **widespread stigma and discrimination** which can create significant barriers to HIV care. Transgender-related stigma is associated with **lower self-esteem**, **increased likelihood of substance abuse** and a high prevalence of **survival sex work**, particularly among MTFs.[21] **Social marginalization** resulting from discrimination can result in the denial of educational, employment, and housing opportunities to transgender persons, factors that can reduce utilization of health services by forcing individuals to focus on **survival issues**. Transgender persons also frequently lack access to health services due to low socioeconomic status, lack of insurance, fear of transgender status being revealed, and a lack of provider knowledge of these populations. Because of high rates of poverty, transgender persons are disproportionately dependent on the Ryan White system of care to help support core medical services. The annual **cost** of providing HIV-related services to transgender persons in the San Francisco EMA is estimated to be at least **$5,625,000** per year.[22]

Emerging Population # 3: Men of Color Who Have Sex with Men (MSM): MSM make up by far the most heavily HIV-impacted population in the San Francisco EMA, accounting for **81.8%** of all persons living with HIV and AIDS as of December 31, 2007, including MSM who inject drugs (n=**19,458**). At least **6,000** of these individuals - or **31%** of the HIV-infected MSM population of the EMA - are people of color, most of them **African Americans** and **Latinos**. Within Latino and Hispanic communities EMA-wide, MSM make up **81.7%** of all persons living with HIV/AIDS, including **72.6%** infected through MSM contact and **9.1%** infected through MSM contact and injection drug use. Among Asian and Pacific Islander groups, the percentage is even larger, with MSM accounting for **79.3%** of all persons living with HIV/AIDS, including **74.7%** MSM only cases and **6.0%** MSM/IDU cases. The percentage of MSM cases among African Americans is somewhat lower, largely due to the fact that a much higher proportion of African Americans living with HIV and AIDS are women. A total of **54.2%** of all African Americans living with HIV and AIDS in the EMA were infected through male-male sexual contact as of mid-2006, including **39.6%** through MSM contact alone and **14.6%** who had male-male sex and injection drug use as co-factors. MSM of color in the San Francisco EMA tend to be poorer; have less access to preventive health care; have lower rates of private insurance; and have higher levels of co-morbidities. MSM of color are also believed to have significantly higher levels of unmet need than white MSM. Prior needs assessments have found that perceived **structural barriers,** such as restrictive or complex rules for entering service, and perceived **lack of service access** were cited most frequently as barriers to care for MSM of color, with more than **half** of assessment respondents saying they were likely to have a problem related to these factors. Lack of insurance; the high cost of care; not knowing services are available; and perceived lack of confidentiality were cited as particular barriers to care among MSM

who reported being out of care **for a year or more**. The annual **cost** of providing HIV-related services to men of color who have sex with men is estimated at **$84,180,000**.[23]

Emerging Population # 4: Homeless Individuals: Homelessness is an ongoing crisis for the San Francisco EMA, contributing to high rates of HIV infection, and creating an intensive need for integrated, tailored services which bring homeless individuals into care, stabilize their life circumstances, and retain them in treatment. At least **1,666** HIV-infected homeless individuals are estimated to be living with HIV or AIDS in the San Francisco EMA each year (based on an overall 7% homelessness rate among PLWHA), and at least **42%** of them are estimated to be out of care. Because of their disconnection from health and social service systems, homeless individuals are the population **least likely** to obtain regular health or preventive care. **Clearly, the most pressing immediate service need for HIV-infected homeless people is to help them obtain safe, stable housing that allows them to enter care and to remain compliant with HIV medications.** However, the scarcity of housing resources in the EMA makes it difficult for HIV-infected homeless people to enter housing quickly, and many homeless individuals are lost to care while they are awaiting housing. Rates of mental illness and substance addiction are also disproportionately high among the homeless, complicating both outreach and care provision, and necessitating integrated service programs such as the Centers of Excellence initiative. The annual **cost** of providing HIV-related services to homeless individuals is estimated at **$20,000,000**.[24]

Emerging Population # 5: African Americans: The growing crisis of HIV among African Americans in the San Francisco EMA is a cause for significant concern. As of December 31, 2007, a total of **3,568** African Americans were estimated to be living with HIV/AIDS in the EMA, representing **15.0%** of the region's HIV-infected population, despite the fact that only **5.3%** of the EMA's population is African American. At the same time, fully **18.4%** of all those diagnosed with AIDS between January 1, 2006 and December 31, 2007 were African American – a percentage **22%** higher than their representation in the overall PLWHA population. At least **35%** of all African Americans living with HIV in the San Francisco EMA are currently estimated to be out of care - a proportion comparable to the percentage of homeless persons out of care. The reasons for this under-representation include: a) higher prevailing rates of poverty and unemployment, leading to lower rates of private insurance and health care utilization; b) high rates of injection drug use and homelessness, leading to an unwillingness or difficulty in accessing care; and c) a shortage of HIV-specific services in African American neighborhoods. Of the 183 African Americans surveyed for the EMA's previous Needs Assessment, **49.3%** reported having no insurance of any kind, and **53.3%** reported a high or complete disconnection from care, with frequently cited barriers including: fear of governmental health services; lack of culturally competent services; frustration with long waiting lists; and a lower prioritization of health care due to competing needs driven by poverty and racism. In order to successfully reach more HIV-infected African Americans, the local care system must do a better job of informing African Americans of the importance of HIV testing and treatment, and must be more aggressive in locating culturally appropriate services within black neighborhoods**. The new Southeast Partnership for Health – a Center of Excellence recently created**

in the Bayview-Hunters Point neighborhood – has begun to make a significant contribution toward addressing this discrepancy. The annual **cost** of providing HIV-related services to African Americans is estimated at **$43,668,000**.[25]

Emerging Population # 6: Latinos: In the San Francisco EMA, Latino and Hispanic populations are making up an increasingly larger share of the region's total HIV-infected population. While **15.3%** of all those estimated to be living with HIV and AIDS in the EMA as of December 31, 2007 were Latino/a, **17.1%** of new AIDS cases diagnosed between January 1, 2006 and December 31, 2007 were among Latino/as, with a total of **3,638** Latino/a PLWHA estimated to be living in the EMA as of December 31, 2007. According to the most recent San Francisco HIV Epidemiology Report, Latinos represent **30%** of adolescent AIDS cases age 13-24 in the city - an overrepresentation when compared to the **23%** of the general adolescent population of San Francisco which is Latino/a. As with African American populations, a lack of access to health care, higher rates of poverty and unemployment, and a disconnection from health and social services contribute to relatively high rates of unmet need among Latino/a populations. According to the US Census, in the City of San Francisco, **11.1%** of the city's population speaks Spanish as their primary language, with **26.5%** of those who speak Spanish as their primary language reporting they speak English either not well or not at all. This requires that HIV services be provided in Spanish throughout the EMA, by culturally competent professionals who understand the health beliefs and practices of Latino/a communities. Fear of deportation also leads to a reluctance to seek HIV testing or treatment. The annual **cost** of providing HIV-related services to Latino populations is estimated at **$45,846,000**.[26]

D. ORGANIZATION OF CURRENT RESPONSE TO THE EPIDEMIC

The grantee agency for Ryan White Part A funds in the San Francisco EMA is the **City and County of San Francisco Department of Public Health.** Ultimate authority for the administration and expenditure of Part A funds lies with the city's **Mayor, Gavin Newsom**, and with the city's 11-member **Board of Supervisors**, which acts as both county governing board and city council for San Francisco. This authority is shared with **Mitch Katz, M.D.,** who serves as **Director of Public Health** for San Francisco. The administrative unit overseeing the Part A grant is **HIV Health Services**, an organizational unit physically located at the San Francisco AIDS Office, overseen by **Barbara Garcia** who serves as **Deputy Director for Health** for the City and County of San Francisco**.** The **Director of HIV Health Services** is **Michelle Long**, who has served in this capacity for **ten** years. A staff of **16** individuals - each funded with different levels of Part A support - is responsible for directing, coordinating, and monitoring distribution and expenditure of Part A funds throughout the EMA. The EMA's quality management and unmet needs framework activities are coordinated in part through subcontracts with outside consultants.

San Francisco HIV Health Services works in close partnership with the **San Francisco HIV Health Services Planning Council**, a community planning group with a maximum of **40** seats that meets monthly to oversee the prioritization, allocation, and effective utilization of Ryan White Part A and B funds. At the time of this writing, the Council's work is coordinated by **three Co-Chairs**, **Laura Thomas, Steve Manley,** and **Mark Molnar**. Co-Chairs are elected annually and serve two-year terms, and also serve on the Council's **15-member Steering Committee,** which meets on a monthly basis with HIV Health Services staff to coordinate key Council activities and decision-making. Three additional standing committees support the work of the Council: the **Consumer and Minority Affairs Committee;** the **Government and Provider Affairs Committee and** the **Membership Committee.** Administrative support for the San Francisco HIV Health Services Planning Council is provided through a subcontract to **Shanti, a non-profit service organization.** The newly appointed **Director** of Planning Council Support is **Greg Zhovreboff.**

The two additional counties that make up the San Francisco Eligible Metropolitan Area have responsibility for administration and distribution of Part A funds through their counties' respective health departments. In San Mateo County, Part A funds are coordinated through the **San Mateo County Health Services Agency** and the Agency's **Director, Charlene Silva.** Day-to-day responsibility for Part A fund administration lies with **Dennis Israelski, M.D.**, who serves as **Medical Director** for the **San Mateo County AIDS Program** and with **Ellen Sweetin,** who serves as **Associate Director** of the AIDS Program. In Marin County, Part A funds are administered through **County of Marin Health and Human Services**, whose **Director** is **Larry Meredith, Ph.D.**, who shares responsibility for Part A funds with **Frima Steward, Assistant Director of Public Health Services.** The **Marin County HIV/AIDS Program** has direct responsibility for Part A fund management and coordination, through oversight by **Sparkie Spaeth**, who serves as **Community Health and Prevention Services Manager** for the County.

E. ASSESSMENT OF NEED

Issues in the Delivery of HIV Services

The San Francisco EMA HIV system of care - a system that has served for decades as a national model of effective HIV service delivery - is today facing an economic crisis which threatens both the quality and availability of care for persons with HIV/AIDS in our region. This crisis stems from a convergence of factors which together creates an environment in which our system may soon be unable to meet the needs of the HIV-infected populations it was designed to serve, including being unable to bring the most needy and underserved populations into primary medical care and retain them on combination therapies. The factors underlying this threat fall into **three** broad categories: **1)** The growing population of persons living with HIV infection, including individuals with complex and multiple needs; **2)** The concentration of HIV and AIDS cases within a relatively small geographic area, especially in the case of San Francisco; and **3)** An integrated and escalating series of co-morbidities which threaten to swamp the system and create overwhelming demands on care providers. Each of these categories - described briefly below - places a special burden on the system of care, and presents daunting challenges to a Planning Council struggling to maintain an adequate level of support for **all** impoverished persons with HIV.

Growing Population of Persons with HIV, including Individuals with Multiple Needs: It is important to remember that despite diminishing financial resources, there are today more persons living with HIV in the San Francisco EMA than at any point in the history of the epidemic - an increase of more than 50% over the last 12 years alone. This crisis requires increased resources, not reduced ones. The estimated **23,794** persons living with HIV and AIDS as of December 31, 2007 represent **86%** of the total 27,592 AIDS cases **ever diagnosed** in the San Francisco EMA, and is **nearly 20% more** than the approximately 20,000 people who have died from AIDS in our region since the start of the epidemic. Because of our unparalleled success in bringing large percentages of persons with HIV into care, supporting the cost of their medications and treatment, and providing support to help them remain stable and compliant, persons with HIV in our region are **living much longer and more productive lives** than would ever have been thought possible, while progressing to AIDS at an progressively slower rate – this in spite of the growing need and complexity of HIV-infected population. **The reduction in the rate of new annual AIDS cases in our region is a sign of the success of our system of care in preventing HIV-infected people from progressing to AIDS.**

However, local HIV-infected populations are not only growing – they are becoming **much more difficult to serve**, presenting a greater range of pre-existing physical, psychosocial, and financial issues than at any point in the past. Findings from 2006 Reggie data for the City of San Francisco revealed that **more than half** (**55.7%**) of all HIV clients in care meet at least **two** of the criteria for "severe need" populations, including severe and

persistent mental illness, homelessness, and/or active substance addiction. A recent study by the California Endowment demonstrated that between 1996 and 2001, the ratio of units of service to total unduplicated HIV clients in our EMA **increased dramatically,** meaning that clients are requiring more service visits and a higher volume of care based on their increasingly complex needs.[27] San Francisco is also seeing an increase in the percentage of young people aged 13-29 who **test late** for HIV, defined as developing AIDS within 12 months of an HIV diagnosis or receiving an HIV and AIDS diagnosis concurrently. **More than half (54%) of all 13-29-year-olds diagnosed with AIDS in San Francisco between 2003 and 2006 were late testers**, indicating a growing population of risk-taking youth who are unaware of or in denial regarding their HIV status.[28]

The facts of the local epidemic are staggering. **Sixty-two percent** of persons living with HIV and AIDS and **one hundred percent** of persons in the Ryan White system are living at or below 300% of federal poverty level.[29] **Twenty-five percent** of persons with HIV have no form of health insurance.[30] **Nearly one in ten** persons newly diagnosed with AIDS in the EMA are homeless.[31] As many as **half** of MSM living with HIV in the EMA suffer from depression.[32] **Thirty percent** of local PLWHA are active substance users.[33] **One in seven** persons with HIV in the EMA speaks a primary language other than English.[34] **As many as one-third** of gay-identified men in the San Francisco EMA may be HIV-infected.[35] **Thirty-five percent** or more of transgender persons are believed to be HIV-infected, including **over half** of all African American male-to-female transgender persons.[36] And the list goes on.

Ironically, it is precisely because the San Francisco system of care has been so successful at bringing people into care and preserving their health that the system faces the unprecedented pressures with which it is currently struggling to cope. Our success in increasing lifespan compels the system to provide supportive services for a much longer term of infection, including financing expensive medications for a growing population over a longer period of time. At the same time, more and more individuals **move** to the San Francisco EMA to access its high level of services, creating a growing burden on the system from outside the region. All PLWA participating in the previous San Francisco HIV Needs Assessment, for example, were asked **where** they had received their original AIDS diagnosis; **24.5%** reported that they had been diagnosed with AIDS **outside** the EMA, and had moved to the region to receive care.[37] This percentage is believed to be similar for persons living with HIV.

Concentration of HIV/AIDS Cases: Imagine yourself standing in a crowded bus or train during rush hour in a major U.S. city. If you are on that train in San Francisco, the odds are extremely high that at least **two** people on your train will have HIV. As noted above, **1 in every 37** residents of the city is currently living with HIV disease, including as many as **one out of every four** gay-identified men. In most major U.S. cities, the burden of the HIV epidemic is spread across a relatively large region, with more facilities available to provide care for broadly dispersed groups of patients. The City of San Francisco, however, is **less than seven miles long by seven miles wide,** which means that this population must be

cared for within a **very limited space** that has fewer health and social service facilities available to meet client needs.

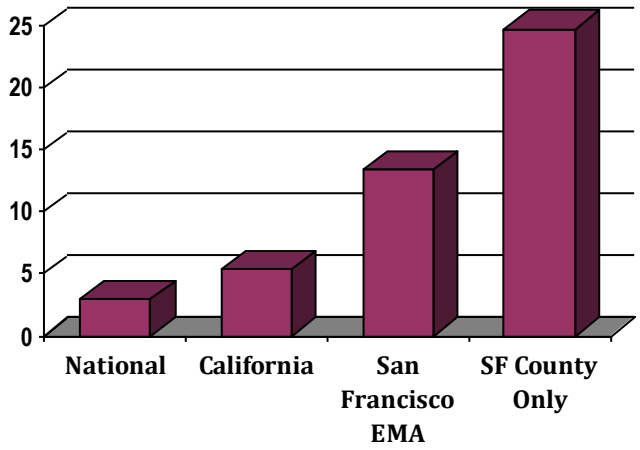
In San Francisco, the concentrated demand results in HIV services being compressed within individual provider agencies that are struggling to cope with HIV caseloads many times larger than they were originally established to serve. Lag times between initial inquiries and appointments are becoming progressively longer, and clients are experiencing greater delays in obtaining key services. The increasing complexity of HIV-infected populations also means that local agencies must cobble together unorthodox combinations of full-time and part-time staff, resulting in high levels of employee turnover and attrition.

Escalating Co-Morbidities: A number of key co-morbidities contribute to the growing complexity of the HIV epidemic in the San Francisco EMA and the ongoing demand these issues place on the Ryan White Act-funded service system. These include problems related to: a) sexually transmitted infections; b) the high cost of housing and resulting homelessness; c) lack of insurance coverage; d) widespread poverty; e) the high percentage of formerly incarcerated individuals in our region; f) the growing problem of substance abuse and related infections; and g) mental illness and mental health issues. Each of these issues is briefly described in the section below, along with summary estimates of the specific costs to the system associated with each issue.

- **Sexually Transmitted Infections**

While San Francisco's per capita HIV infection rates continue to rise, the growing crisis of **sexually transmitted infections** provides an ominous marker for the future of the HIV epidemic in our region, with San Francisco County frequently having what are by far the highest rates of syphilis and gonorrhea of any county in California. In terms of **syphilis,** for example, the San Francisco EMA continues to confront a highly publicized epidemic that has been escalating for the past half decade, **rising more than 500% since 2000.** The total of **228** new primary and secondary syphilis cases diagnosed in the EMA in 2007 represents a welcome decrease from the **280** total cases reported in 2006 and the **364** cases reported in 2004, attesting to the emerging success of local efforts to address the crisis.[38] Within the

Figure 9. 2007 New Primary & Secondary Syphilis Cases Per 100,000 Population

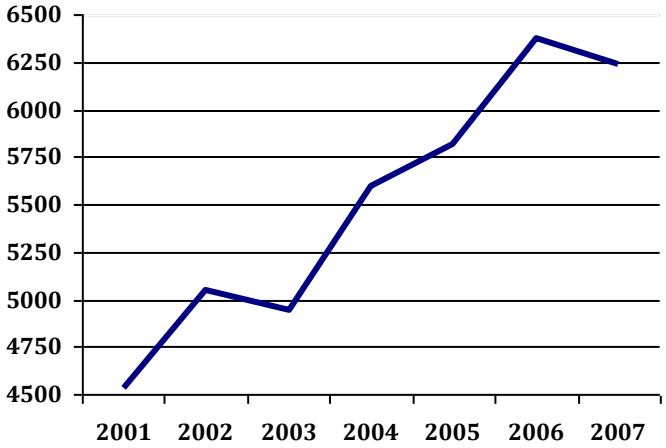


City of San Francisco, a total of **202** new syphilis cases were reported in 2007, **39** fewer cases than the **241** cases diagnosed in 2006, for a **16.2%** reduction.[39] However, despite this progress, 2007 syphilis incidence rates of **13.4** cases per 100,000 for the EMA as a whole and **24.7** cases per 100,000 in San Francisco are nearly **3 times** and **5 times higher**, respectively, than the 2007 statewide rate of **5.4** cases per 100,000, and more than **4 times** and **8 times higher,** respectively, than the national syphilis rate of **3.0** cases per 100,000 in 2005 (see Figure 9), suggesting continued increases in new HIV infections in the EMA over the foreseeable future.[40] San Francisco County has by far the largest rate of syphilis infections of any county in California, nearly **three times** that of Los Angeles County (**9.1** per 100,000); more than **double** the rate of San Diego County (**11.2** per 100,000); and **seven times** the rate of Santa Clara County (**3.1** per 100,000).[41]

A comparable epidemic of **gonorrhea** is also underway in our EMA. A total of **2,348** new gonorrhea cases were identified in the San Francisco EMA in 2007, an increase of **13%** over the **2,084** cases diagnosed in 2003.[42] A total of **2,015,** or **86%** of the EMA's 2007 gonorrhea cases occurred in the City of San Francisco. The EMA-wide incidence of **138.25** cases per 100,000 is **20% higher** than the 2005 national rate of **115.6** cases per 100,000 and **nearly 70% higher** the 2007 California rate of **82.6** cases per 100,000.[43] San Francisco's 2007 incidence of **246.5** cases per 100,000 is **more than double** the national rate and is **200% higher** than the statewide rate, and is again by far the highest rate of any county in California, with the next highest county – Sacramento County - having a case rate **nearly 60% lower** than San Francisco's (**155.3** per 100,000)**.**[44] Many of the EMA's new gonorrhea cases are occurring among **young women aged 15 – 24,** who accounted for **210** cases in 2007. The gonorrhea rate of **461.2** per 100,000 15-24-year-old women in San Francisco is **22% higher** than the statewide rate of **344.9** per 100,000.[45]

The San Francisco EMA's **chlamydia** epidemic continues to rise precipitously, although rates in EMA are much more comparable to national and statewide averages . A total of **6,242** new cases of chlamydia were diagnosed in the San Francisco EMA in 2007. Although this represents an encouraging reduction from the **6,369** new Chlamydia cases identified in 2006, it also represents a **7.3% increase** over the **5,816** cases diagnosed in 2005 and a stunning **37%** increase since 2001 (see Figure 10). [46] The 2007 EMA-wide Chlamydia incidence stood at **367.5** per 100,000, while the rate for the City of San Francisco was at **481.8** cases per 100,000.[47] By comparison, the 2007 incidence for California was **378.4** cases per 100,000

Figure 10. Annual Reported Chlamydia Cases - San Francisco EMA - 2001-2007



while the 2005 federal level was **332.5** per 100,000.[48]

The cost of treating STIs adds significantly to the cost of HIV care in the San Francisco EMA. According to a recent study which estimated the direct medical cost of STIs among American youth (Chesson, et al., 2004), the total cost of the **9 million** new STI cases occurring among 15-24 year olds totaled **$6.5 billion** in the year 2000 alone, at a per capita cost of **$7,220 per person.**[49] Lissovoy, et al. (1995) estimated 1990 US national medical expenditures for congenital syphilis for the first year following diagnosis at between **$6.2 million** and **$47 million** for **4,400** cases, or as high as **$10,682** per case.[50] A 2003 study published in the *American Journal of Public Health* estimated that in 2000, a total of **545** new cases of HIV infection among African Americans could be attributed to the **facilitative effects of infectious syphilis**, at a cost of about **$113 million**, or a per capita cost of **$20,730.**[51] Such studies suggest that the total cost of treating new STIs in the SF EMA may be as high as **$11.4 million** per year, including an estimated **$2.97 million** to treat STIs among persons with HIV, with another **$75 million** in costs potentially resulting from the need to treat persons infected with HIV as a result of transmission facilitated through other STIs.[52]

- **Housing and Homelessness:**

Housing is an indispensable link in the chain of care for persons with HIV. Without adequate, stable housing it is virtually impossible for individuals to access primary care; begin and maintain combination therapy; and preserve overall health and wellness. These issues are even more critical for persons with co-morbidities such as substance addiction or mental illness, since maintaining sobriety and medication adherence is much more difficult without stable housing. Homelessness is also a critical risk factor for HIV itself, with one national study reporting one or more HIV risk factors among **69%** of homeless persons.[53]

Because of the prohibitively high cost of housing in the San Francisco EMA and the shortage of safe and affordable rental units, the problem of homelessness has reached crisis proportions, creating formidable challenges for organizations seeking to serve HIV-infected populations – challenges that have significantly increased since the new restrictions on the housing category under the Ryan White HIV/AIDS Treatment Modernization Act of 2006. According to the National Low Income Housing Coalition's authoritative *Out of Reach 2005* report, for example, Marin, San Francisco, and San Mateo Counties – the three counties that make up the San Francisco EMA – are, incredibly, **tied with one another** as the **three least affordable counties in the nation** in terms of the hourly wage needed to rent a two-bedroom apartment, which currently stands at **$29.54 per hour** (see Figure 11).[54] The San Francisco metropolitan region also ranks as the **most expensive metropolitan region in the US** in terms of the same statistic.[55] Meanwhile, the San Francisco Metropolitan Area has the **highest HUD-established Fair Market Rental rate in the nation**, representing the amount needed to "pay the gross rent

(shelter plus utilities) of privately owned, decent, and safe rental housing of a modest (non-luxury) nature with suitable amenities".[56]

Figure 11.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs[57]

County	Hourly Wage Needed to Rent a Two-Bedroom Apartment at HUD Fair Market Rent
Marin County, CA	$ 29.54
San Francisco County, CA	$ 29.54
San Mateo County, CA	$ 29.54
Ventura County, CA	$ 28.12
Orange County, CA	$ 26.77
Santa Cruz County, CA	$ 25.83
Alameda County, CA	$ 25.75
Contra Costa County, CA	$ 25.75
Nantucket County, MA	$ 25.62
Westchester County, NY	$ 25.31

On January 26, 2005, the City of San Francisco conducted a 24-hour homeless count which identified a total of **6,248** homeless men and women living on the streets or in jails, shelters, rehabilitation centers, or other emergency facilities.[58] San Francisco also copes with an additional **3,000 - 7,000** temporarily homeless individuals per year, which means that - with anywhere from **11,640** to **15,640** homeless per year - the city has the **second highest per capita homelessness rate of any city in the U.S**.[59] A recent study by the University of California San Francisco found that the city's chronic homeless population has also continued to age**,** with a current median age among these groups estimated at **50** - up from **37** years of age when population studies first began in 1990.[60] Aging contributes to chronic diseases related to homelessness, including high rates of diabetes and hypertension, and complicates the problem of providing care to these groups. Combining the data for San Francisco, Marin, and San Mateo counties, we estimate that **26,640** individuals experience homelessness at some point during the year, including an estimated **13,500** chronically homeless individuals and **13,140** temporarily homeless persons.

Homelessness has a distinct and well-established link to HIV disease. HIV prevalence studies among homeless adults in San Francisco have produced estimates ranging from a **9%** HIV prevalence rate among the general homeless adult population[61] to an astounding **41%** among marginally housed adult MSM.[62] Among the hundreds and possibly thousands of homeless youth in San Francisco - a city which still serves as a Mecca for runaway and low-income youth - estimated HIV prevalence ranges from **29%** among young homeless gay and bisexual males[63] to **68%** among gay and bisexual male teens who enter homeless youth centers.[64] HIV diagnosis itself also frequently **results** in homelessness, with the percentage of persons who were homeless at the time of AIDS diagnosis increasing in the City of San Francisco from **3%** in 1992 to **9%** in 2007, although this percentage has declined from a high of **14%** in the year 2000.[65]

The burden of **costs** that homelessness places on the local system of care is difficult to calculate, but adds significantly to the price of HIV/AIDS care. **According to a 2004 report by the Lewin Group, San Francisco had the highest cost per day for serving homeless individuals among nine major cities studied – cities which included New York and Los Angeles.**[66] A study by the San Francisco Department of Public Health Housing and Urban Health Division found that the annual cost of medical care for homeless men and women averaged **$21,000** for inpatient, emergency department, and skilled nursing facility care, a figure which decreased to an average **$4,000** per year for individuals placed in permanent subsidized housing.[67] Meanwhile, a two-year University of Texas survey of homeless individuals found that the public cost of caring for the homeless averaged **$14,480** per person per year, primarily for overnight jail stays.[68] Overall, we estimate that the total costs of homelessness add at least an additional **$16.66 million** to the cost of care for HIV-positive individuals within the EMA **–** costs that do not take into account the higher rates of HIV infection among homeless populations.[69]

- **Insurance Coverage:**

Based on findings of the 2005 California Health Interview Survey conducted by the UCLA Center for Health Policy Research – the most recent version available - an estimated **14.3%** of San Francisco EMA residents under the age of 65 are believed to be without **any** form of insurance coverage - including Medicaid - for a total of **214,995** uninsured individuals under 65 in our region (persons 65 and older are excluded because of the availability of Medicare at age 65).[70] This includes an estimated **15.5%** uninsured in San Francisco; **14.2%** uninsured in San Mateo County; and **11.0%** uninsured in Marin County.[71] **The lack of health insurance is a significant barrier to care, placing incalculable financial burdens on the system, particularly in the San Francisco EMA, which has extremely high medical costs.** According to current Reggie data, **49.5%** of San Francisco Ryan White system clients are covered by Medicaid, but **25.1%**lack **any** form of insurance coverage. Meanwhile, among those persons with HIV who are not in care or are unaware of their HIV status, the uninsured rate is believed to be much higher than the general population, since HIV-infected people in the EMA are disproportionately poor, and many who are not in care have not yet applied for Medicaid. We estimate that the **cost** to the system of serving uninsured and indigent populations living with HIV is at least **$85 million** annually, based on an average **25.1%** uninsured rate among persons living with HIV/AIDS in care (n=**4,250)** at an estimated annual average cost of **$20,000** per person for HIV treatment and medications. However, the overall picture of the uninsured in San Francisco has begun to change. The city is currently engaged in the nationally recognized initiative **Healthy San Francisco** initiative, designed to ensure universal health care access to the city's estimated **82,000** uninsured. The EMA will continue to track the ongoing impact of this program on both access and quality of care for PLWHA in our region.

- **Poverty:**

The problem of homelessness is closely tied to that of **poverty**, and presents another daunting challenge to the HIV care system. Using poverty data from the 2000 Census updated to 2006 population estimates, we project that **810,420** individuals in the San Francisco EMA are living at or below 300% of Federal Poverty Level, which translates to **47.7%** of the overall EMA population lacking resources to cover all but the most basic expenses.[72] **However, because of the high cost of living in the San Francisco Bay Area, persons at 300% of poverty or below have a much more difficult time surviving in our area than those living at these income levels in other parts of the U.S.** Analyzing data from Reggie, the San Francisco client-level data system, we estimate that at least **62.1%** of all persons living with HIV and AIDS in the San Francisco EMA (n=**14,786**) are living at or below 300% of the 2008 Federal Poverty Level (FPL) - including persons in impoverished households – with **100%** of Ryan White-funded clients living at or below 300% of poverty.[73] Reggie data reveals that **40%** of active Ryan White clients in San Francisco are currently living on incomes of **less than $10,000 per year**, and **17%** are surviving on incomes of less than $5,000 per year. HIV-infected persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **$108 million** in Part A and non-Part A HIV-related expenditures each year.[74]

- **Recently Incarcerated Individuals:**

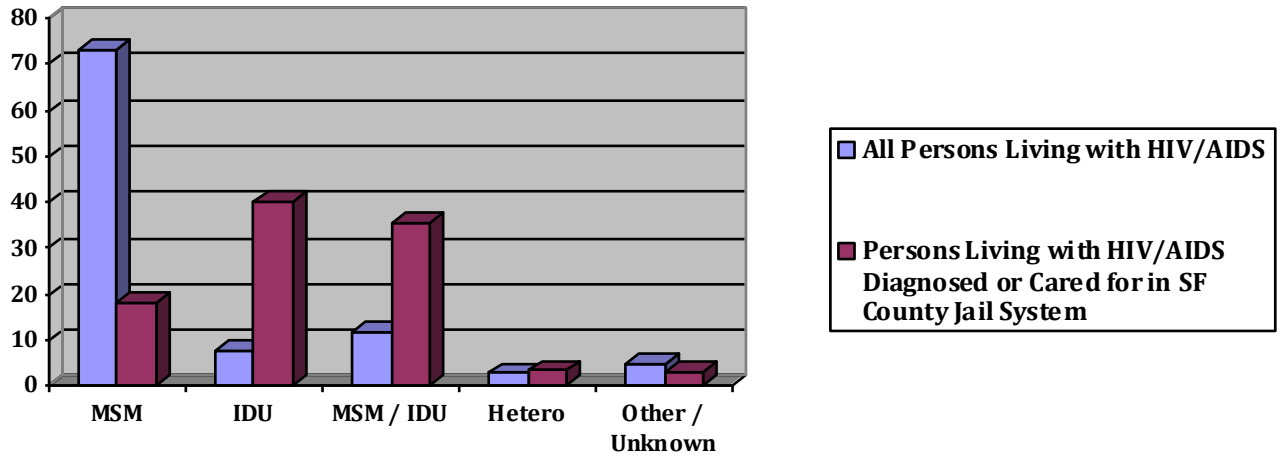
The San Francisco EMA HIV service system incorporates a large number of formerly incarcerated individuals who pose additional significant challenges to the provision of effective HIV services in our region. As noted above, the California Department of Corrections reports that an average total of **5,134** persons were being held in jail settings **each day** in the San Francisco EMA during 2005,[75] while a minimum of **65,000** bookings took place in the three-county region.[76] Over the preceding three-year period, local Reggie data shows that a total of at least **770** formerly incarcerated individuals received Ryan White services between July 1, 2004 and June 30, 2007, representing approximately **13.9%** of the city's total Ryan White-funded caseload of **5,535** as of February 28, 2007. This represents a three-year past incarceration rate of **13,911** per 100,000 – a rate **more than four times** that of the general population. At the same time, epidemiological data provided by the San Francisco Health Department reveals that a total of **840** persons living with HIV/AIDS as of December 31, 2006 had been diagnosed or had received HIV services within the San Francisco County Jail System.

The San Francisco EMA is also home to **San Quentin State Prison**, California's oldest and largest prison, which contains the state's only death row. Opened in July 1852, the prison houses an average daily population of **5,222** inmates in facilities originally designed to house 3,317 individuals. The prison serves as the identification point for a large number of persons with HIV, many of whom remain in the San Francisco Bay Area to seek HIV services following release. Over the three years from January 1, 2004 to December 31, 2006 a total of **51** persons were diagnosed with HIV at San Quentin Prison, including **46** male and **5** transgender individuals. Nearly **one-third** of these (**29%**) were infected through injection drug use alone, as compared to **9%** of all persons living with HIV/AIDS in the

EMA. **African Americans** are highly overrepresented among the San Quentin HIV-diagnosed population, representing **45%** of all HIV cases diagnosed in the facility from 2004 to 2006.

An analysis of epidemiological and client data reveal a range of demographic and economic factors that indicate vastly increased levels of cost and complexity of care for formerly incarcerated populations with HIV in our region. For example, of the **840** individuals who had been diagnosed with or received HIV care in San Francisco jails in 2006, fully **14.4%** were women – **more than double** the percentage of women living with HIV/AIDS in the EMA as of that date (**7.1%**). At the same time, **7.7%** of those diagnosed with or receiving care for HIV in San Francisco jails were **transgender persons – more than three times** their representation among the EMA's total PLWHA population (**1.8%**). Reflecting significantly higher rates of injection drug use among incarcerated populations, **39.9%** of persons with HIV in the San Francisco jail system had been infected through injection drug use alone, as compared to **9.0%** of the overall PLWHA population, while MSM / IDU cases accounted for **35.6%** of jail populations, versus **11.1%** for this group within the total PLWHA population (see Figure 12). These findings are reflected in a recent study of young injectors under age 30 in San Francisco, which found that **86%** had a lifetime history of incarceration; **56%** had been incarcerated in the past year; and **42%** were infected with hepatitis C – a critical marker of potential HIV infection.[77] Equally alarming is the high overrepresentation by **African Americans** among formerly incarcerated persons with HIV in San Francisco, who account for **44.5%** of all PLWHA diagnosed with HIV or provided with HIV care in San Francisco jails, despite making up **14.1%** of the total PLWHA population of the San Francisco EMA.

Figure 12. Comparison of Overall PLWHA Population with PLWHA Population Diagnosed / Cared For in SF County Jail System as of 12/31/06 by Transmission Category



The crisis of HIV among incarcerated and formerly incarcerated populations has consistently been met with specific and focused responses to meet the needs of these populations in our region. Objective # 4.4 of the EMA's most recent Comprehensive Plan specifically calls on the local system to "continue to develop systems and partnerships that ensure that persons who are in prison or incarcerated are fully linked to care upon their release from the jail and prison systems." When the EMA created its nationally recognized **Regional Centers of HIV Excellence** program in November 2005, one of the seven new centers funded was **Forensic AIDS Project** – a unique collaborative coordinated by the San Francisco Health Department, providing jail-based health services and post-release treatment and care linkage services to incarcerated persons with HIV. Forensic AIDS Project offers screening, support, and medical case management services for virtually **all** individuals leaving the local jail system, and ensures a smooth transition in terms of both medical care and social services.

The precise burden of **costs** related to the high rates of recent incarceration among PLWHA populations in the San Francisco EMA is difficult to calculate. However, demographic characteristics of this population – including a higher percentage of women and transgender persons with low incomes; greater representation by African Americans with low incomes; and greatly expanded rates of injection drug use – point to severe need requiring specialized support and assistance that significantly increases the cost of HIV care. Annual services by Forensic AIDS Project, for example, are currently are budgeted at **$335,000** per year, a figure that includes only immediate post-release care and service linkage. Additional costs related to higher rates of HIV infection related to incarceration itself may total at least **$1.37 million** per year in additional direct incarceration-related HIV expenditures for the San Francisco EMA.[78]

- **Substance Use and Related Infections:**

The problem of **substance use** plays a central role in the dynamics of the HIV epidemic, creating challenges for providers, while presenting a critical barrier to care for HIV-infected consumers. The EMA is in the throes of a **major substance abuse epidemic,** an epidemic which is fueling the spread not only of HIV but of co-morbidities such as STIs, hepatitis C, mental illness, and homelessness - conditions that complicate our ability to bring and retain PLWHA in care. According to the Office of National Drug Control Policy, San Francisco has the **second highest rate of drug-related emergency room admissions** and the **second highest number of drug-related arrests of any city in the U.S.**,[79] while drug poisoning/overdose is the city's **third** leading cause of premature death.[80] Drugs and drug-related poisonings are also the **leading** cause of injury deaths among San Franciscans, **with nearly three San Franciscans dying each week of a drug-related overdose or poisoning**.[81]

In terms of HIV, the most alarming current threat involves the local epidemic of **methamphetamine,** or **speed.** Health experts currently estimate that up to **40%** of gay men in San Francisco have tried methamphetamine,[82] and recreational crystal use has been

linked to **30%** of San Francisco's new HIV infections in recent years.[83] Because meth is frequently injected, the drug presents a threat similar to heroin in terms of its ability to transmit HIV via needle use. A study by the San Francisco Department of Public Health among **347** men attending late-night MSM venues found that **46%** of participants reported a history of injection drug use, nearly all of which (**94%**) involved injection of **methamphetamines.[84] Heroin** use also remains a critical problem in the San Francisco EMA, used by at least **half** of the estimated **17,832** injection drug users in the region (see Emerging Populations section above). However, only about **2,500** heroin users have access to methadone maintenance treatment.

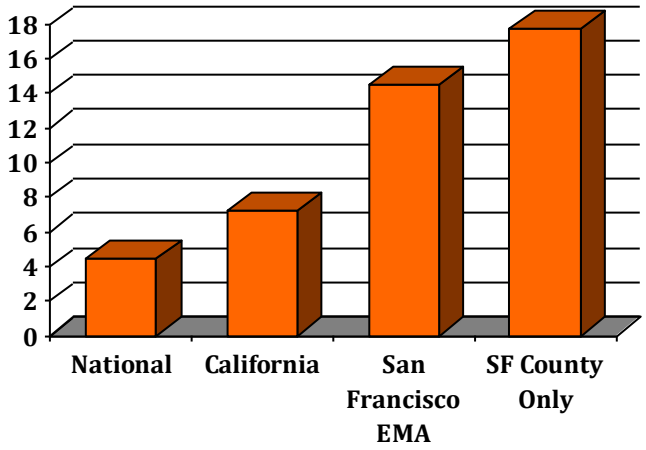
The costs associated with the substance addiction epidemic in the San Francisco EMA add significantly to the local burden of HIV care. According to the National Office of Drug Control Policy, the nationwide societal costs of drug abuse in the year 1998 alone totaled **$143.4 billion.[85]** The National Institute on Drug Abuse reports that it costs an average of **$3,600 per month** to leave a drug abuser untreated in the community, while incarceration related to substance use costs approximately **$3,300 per month.[86]** Such costs can be significantly offset by drug treatment services, which are estimated to save between **$4** and **$7** for every dollar spent on treatment. An average course of methadone maintenance therapy, for example, costs about **$290** per month, while a range of methamphetamine treatment programs currently operating in San Francisco cost between **$2,068** and **4,458** for a single course of treatment.[87]

Injection drug use in the San Francisco EMA is closely related to the growing local epidemic of **hepatitis C**. As of mid-2003 – the most recent dates for which full estimates are available - the San Francisco Department of Health estimated that a total of **22,979** individuals were living with hepatitis C virus (HCV) in San Francisco, for an overall prevalence of **3,057** cases per 100,000, compared to a national prevalence in urban areas of **916.81** per 100,000.[88] Meanwhile, an estimated **13,000** San Mateo County residents are believed to be infected with HCV due to the county's widespread injection drug use epidemic,[89] while Marin County reported **145** new cases in 2003, nearly double the **87** cases reported in 2002.[90] Because it is a blood-borne infection, hepatitis C is closely tied to injection drug use, and is a frequent co-factor for persons living with HIV/AIDS, complicating care and frequently leading to severe long-term health consequences. **The San Francisco Department of Public Health estimates that as many as 90% of all chronic injection drug users over the age of 30 may already be infected with hepatitis C.** Co-infection with hepatitis C can make persons living with HIV unable to take or tolerate new treatments, and is the leading cause of death from chronic liver disease in America.[91] Existing hepatitis C treatments are also costly, and are effective for only about **50%** of people who take them. A single 48-week treatment course of injected interferon plus oral ribavarin costs more than **$20,000.[92]** One study estimated a total of **$10.7 billion** in direct medical care costs related to HCV in the US for the years 2010 to 2019, along with a combined loss of **1.83 million years of life** in those younger than 65 at a societal cost of **$54.2 billion.[93] The HIV care system is rapidly becoming the default medical provider**

for persons with hepatitis C - a trend which, as persons with HCV age, will place enormous cost burdens on the HIV care system.

Tuberculosis (TB) is another critical health factor linked to HIV, particularly in terms of its effects on recent immigrants and the homeless. The magnitude of the local tuberculosis crisis is comparable to that of syphilis and gonorrhea, with a total of **246** new cases of TB diagnosed in the San Francisco Metropolitan Area in 2007, representing an EMA-wide incidence of **14.5** cases per 100,000.[94] In San Francisco, the incidence is even higher, at **17.7** cases per 100,000. **The EMA's tuberculosis incidence rate is more than 50% higher than the statewide rate of 7.2 cases per 100,000, and 245% higher than the national rate of 4.2 cases per 100,000** (see Figure 12).[95] New cases of TB in Marin County alone increased by **166.7%** between 2006 and 2007, from **6** to **16** new TB cases. Rates of new TB infection in San Francisco are highest among Asian populations (**35.3** cases per 100,000 Asian residents), reflecting the disease's heavy impact on recent immigrant populations. Treatment for cases **of multidrug-resistant tuberculosis** are particularly expensive, with one nationwide study indicating that the cost of treating multidrug-resistant TB - including indirect costs to families - averaged **$89,594** per person for those who survived, and as much as **$717,555** for patients who died.[96]

Figure 12. 2007 New Tuberculosis Cases Per 100,000 Population



- **Mental Illness and Mental Health Issues:**

The high prevalence of **mental illness** and **mental health issues** in the San Francisco EMA further complicates the task of delivering effective services and retaining persons with HIV in care. The San Francisco Department of Public Health, Behavioral Health Section reported in its most recent report that **12,000** seriously emotionally disturbed children and youth and **32,000** seriously mentally ill adults live in San Francisco, and that up to **37%** of San Francisco's homeless population suffers from some form of mental illness.[97] In part because of the allure of the Golden Gate Bridge, San Francisco also has one of the nation's highest rates of both adult and teen suicide, with a total of **211** suicides reported in the city in 2002 alone – the last year for which statistics are available.[98] In fact, the rate of suicide per capita in San Francisco is **twice as high** as the city's homicide rate.[99] When coupled with the second highest incidence of homelessness in the US, these factors speak to

a heavy incidence of multiply diagnosed clients in the EMA. Among persons with severe mental illness, the research literature documents a broad range of HIV seroprevalence rates, from **4%** to as high as **23%.**[100] Mental illness, depression, and dementia are also increasingly common among HIV-diagnosed populations, with **31%** of HIV clients at one San Francisco clinic having concomitant mental illness, and **80%** of clients at another clinic having a major psychiatric condition. One recent study found a **37%** prevalence of depression in HIV-infected men in San Francisco.[101]

Unmet Need Estimate

The 2008 unmet need analysis included persons living with AIDS (PLWA) and persons living with HIV/non-AIDS (PLWH) in the San Francisco EMA during the 12-month period from July 1, 2006 through June 30, 2007. The analysis included overall unmet need analyses as well as subpopulation analyses for PLWA and PLWH. These estimates were produced by the SF Department of Public Health HIV/AIDS Statistics and Epidemiology Section, and utilize the unmet need framework methodology developed by the University of California, San Francisco Institute of Health Policy Studies – the framework recommended by HRSA. The timeframe chosen for the unmet need analysis was based on the most recent 12-month interval for which care data were complete from all available data sources.

Based on the unmet needs estimate, we estimate that there were a total of **11,476** PLWA and **10,178** PLWH in the San Francisco EMA from July, 2006 through June, 2007 (see Figure 13 on following page). A total of **1,186** PLWA and **3,536** PLWH did not receive primary medical care during that time period. Unmet need was thus **22%** overall, and - as would be expected - was higher among PLWH (**35%**) than among PLWA (**10%**). The 22% overall unmet need estimate is slightly higher than last year's estimate of 21%.

Limitations: The dataset obtained from the California Part B program contains care data for most publicly insured patients. By conducting medical chart reviews and accessing viral load and CD4 test data, we were able to obtain care information for privately insured patients who sought care in the **same county** in which they resided. Our care data may be incomplete for privately insured patients not at Kaiser who receive care outside their county of residence, particularly in the case of Marin and San Mateo County residents who utilize care providers in San Francisco. However, we believe that the actual volume of missing care data is small, since the majority of PLWA and PLWH in the EMA reside in San Francisco and are likely to seek care within the same county. Additionally, because our estimates of PLWA with met need in San Francisco and San Mateo Counties were derived from county-specific sample proportions rather than from actual counts, they could theoretically include some duplicate individuals. Based on the overlap between the samples and reported PLWA in the San Francisco HARS, and after adjusting for sample sizes relative to the number of reported PLWA in their respective counties, we estimated in a previous analysis that no more than **1%** of the EMA's PLWA in care were likely to be duplicates.

Figure 13. San Francisco EMA Unmet Need Calculation - July 1, 2006 through June 30, 2007

1	2	3	4	5
Population Sizes		**Value**		**Data Source(s)**
A	Number of persons living with AIDS (PLWA) from July 1, 2006 through June 30, 2007	**11,476**		HARS counts (all EMA counties)
B	Number of persons living with HIV (PLWH)/non-AIDS/aware from July 1, 2006 through June 30, 2007	**10,045**		Unduplicated counts from linked databases (SF County); estimate assuming 1.1 ratio of total PLWH (non-AIDS) to PLWA and adjusted for estimated 70% of PLWH (non-AIDS) aware of their infection (Marin/San Mateo Counties).
C	Total number of HIV+/aware from July 1, 2006 through June 30, 2007	**21,521**		Value = A + B
Care Patterns		**Value**		**Data Source(s)**
D	Number of PLWA who received the specified HIV primary medical care from July 1, 2006 through June 30, 2007	**10,290**		Chart reviews, lab reporting data, HARS/ Medi-Cal/ADAP/Kaiser data linkage. Actual met need counts used for Marin County; San Mateo and SF Counties calculated the proportion in care based on representative subsets of PLWA and applied this proportion to their total PLWA populations.
E	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care from July 1, 2006 through June 30, 2007	**6,642**		Unduplicated met need counts from chart reviews, lab reporting data, HARS/Medi-Cal/ADAP/Kaiser data linkage
F	Total number of HIV+/aware who received the specified HIV primary medical care from July 1, 2006 through June 30, 2007	**16,932**		Value = D + E
Calculated Results		**Value**	**%**	**Calculation**
G	Number of PLWA who did not receive the specified HIV primary medical care	**1,186**	**10%**	Value = A - D; Percent = G / A
H	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	**3,403**	**34%**	Value = B - E; Percent = H / B
I	Total HIV+/aware not receiving specified HIV primary medical care	**4,589**	**21%**	Value = G + H; Percent = I / C (quantified estimate of unmet need)

Assessment of Unmet Need: Continually improving and refining the process of determining unmet need remains a high priority for the San Francisco EMA. One of the most important approaches our EMA uses to accurately quantify the full number of persons living with HIV in our region - particularly since HIV reporting did not begin in California until July of 2002 - involves the use of **consensus meetings** in which local and regional researchers, epidemiologists, and community providers participate in a process to estimate the number of persons with HIV living in each of the EMA's counties as a proportion of the total number of persons living with AIDS. The most recent consensus process, conducted between June 2006 and April 2007, allowed us to confidently estimate the PLWH populations of both San Mateo and Marin Counties. Meanwhile, continual improvements in the utilization of the HARS reporting system by the City and County of San Francisco enabled us to utilize **HARS data only** as a basis for quantifying the total number of non-AIDS PLWH living in the city. This allows us to produce much more accurate and detailed representations of PLWH. Our ability to accurately quantify the local PLWH population will improve over time given the implementation of **confidential names-based HIV reporting** by the State of California three years ago.

One of the outcomes of our improved data collection and reporting systems is that we are able to compare specific unmet need among PLWHA from July 1, 2006 through June 30, 2007 across **four** critical categories: **HIV/AIDS status, gender, race/ethnicity,** and **age group** – results that are reported in Figure 14 below. Among all PLWHA populations, our analysis reveals that unmet need was similar for males and females and across race/ethnicity and age categories, attesting to the expanding success of our programs in reaching diverse ethnic populations. Also, as is to be expected, the proportion of persons reporting an unmet need was significantly higher among those with non-AIDS HIV (**35%**) than among those diagnosed with AIDS (**10%**), reflecting the fact that the vast majority of persons diagnosed with AIDS are currently in care, However, in terms of age, **adults aged 20-29** were more likely to have unmet need for medical care than those aged 30 and over (**40%** compared to **29%**), while significant unmet need also exists among persons **aged 30-39**, with **almost one-third** (**29%**) of this population out of care. Persons **aged 50-59 and 60 years or older** were **least** likely to have unmet need (**18%** and **14%,** respectively). **These findings point to the urgency of expanding outreach and service linkage programs related to young adult and recently diagnosed populations**. In terms of youth, the San Francisco EMA service system has for many years been actively engaged in efforts to expand mobile and alternative approaches to HIV testing, and in creating new systems to **immediately** link to care individuals who test positive in both public and private settings. The EMA has developed cooperative outreach programs in collaboration with regional prevention providers - programs that have expanded the proportion of young people who enter our care system annually. At the same time, innovative approaches such as our Centers of Excellence model are designed to expand awareness of and access to HIV services among young people within ethnic minority communities in San Francisco County, and to overcome barriers to care resulting from distrust of the medical system, fear of disclosure of HIV status, and fear of not receiving culturally appropriate services.

Figure 14. San Francisco EMA Demographic Analysis of People in and Out of Care July 1, 2006 through June 30, 2007: ALL Persons Living with HIV or AIDS (PLWHA)*

Characteristic	#1: PLWHA Population	#2: Number with Met Need	#3: Number with Unmet Need	#4: % of Unmet Need Pop.**	#5: % of Category with Unmet Need**	#6: % of Total PLWHA Pop.**
All PLWHA	21,654	16,932	4,722	100%	22%	100%
HIV/AIDS Status						
PLWA	11,476	10,290	1,186	25%	10%	53%
PLWH / no AIDS	10,178	6,642	3,536	75%	35%	47%
Gender						
Male	19,966	15,598	4,368	93%	22%	92%
Female	1,688	1,334	354	7%	21%	8%
Race/Ethnicity:						
White	13,606	10,789	2,817	60%	21%	63%
African American	3,124	2,327	797	17%	26%	14%
Latino	3,329	2,617	712	15%	21%	15%
Asian/PI	1,067	812	255	5%	24%	5%
Other	528	387	141	3%	27%	3%
Age in Years:						
0-19	99	48	51	1%	52%	<1%
20-29	1,029	619	410	9%	40%	5%
30-39	4,107	2,897	1,210	26%	29%	19%
40-49	8,777	7,045	1,732	37%	20%	41%
50-59	5,753	4,691	1,062	22%	18%	27%
60 or older	1,889	1,632	257	5%	14%	8%

* Excludes PLWH (non-AIDS) not aware of their HIV status.
** Column calculations: Column #4 = Column #3 / total with unmet need (n=4,722); Column #5 = Column #3 / Column #1; Column #6 = Column #1 / total number PLWHA (n=21,654).

Gaps in Care

Disproportionate Impact: In terms of ethnic minority representation, both African American and Caucasian populations are **disproportionately affected** by HIV in relation to the overall EMA population, while Latino and Asian/Pacific Islander are **underrepresented** in relation to the general population. Certainly the most dramatic over-representation occurs among **African Americans.** While only **5.3%** of EMA residents are African American, **15.0%** of combined PLWHA populations in the San Francisco EMA are African American, meaning that **nearly three times** the percentage of African Americans are infected with HIV as their proportion in the general population. And while **62.9%** of all PLWHA are white, only **51.2%** of EMA residents are white. By contrast, Asian/Pacific Islanders make up **23.3%** of the EMA's total population, but make up **4.7%** of PLWHA cases while Latinos constitute **15.3%** of PLWA/PLWHA cases but make up **16.9%** of EMA residents. However, new HIV cases will soon create a disproportionate impact among Latinos as well – between January 1, 2006 and December 31, 2007, **17.1%** of newly diagnosed AIDS cases occurred among Hispanics.

Homeless and **formerly incarcerated individuals** are significantly over-represented among persons living with HIV and AIDS in our region. While the combined annual EMA-wide homelessness rate is estimated at **1,571** per 100,000, including an estimated **13,500** chronic homeless and another **13,140** individuals who become homeless at some point each year,[102] the combined annual EMA-wide homelessness rate among persons living with HIV and AIDS is estimated at **7,000** per 100,000[103] - a rate **more than four times** the rate of homeless among the general population. Meanwhile, according to the California Department of Corrections, an average total of **5,134** persons were being held in jail settings **each day** in the San Francisco EMA during 2005,[104] while a minimum of **65,000** bookings took place in the three-county region in 2005.[105] While available reports do not reveal how many of these arrested are among **unduplicated** persons, a conservative estimate based on prevailing recidivism rates would be **17,500** unduplicated individuals arrested and incarcerated each year in the EMA, for an estimated total of **50,000** individuals spending time in incarceration facilities over the past three years - a rate of **3,091** per 100,000. According to San Francisco Reggie data, a total of **770** individuals who had been incarcerated at least once in San Francisco received Ryan White services in the three years between July 1, 2004 and June 30, 2007, representing **13.9%** of the city's total Ryan White caseload of **5,535** as of February 28, 2007, for a three-year incarceration rate of **13,911** per 100,000 – a rate **more than four times** that of the general population.

However, the epidemic's most disproportionate impact remains among gay and bisexual men. Approximately **63,577** gay-identified MSM live in the San Francisco EMA,[106] and an estimated **19,458** of them were HIV infected as of December 31, 2007. **This means that a startling 31% of all gay-identified MSM in the San Francisco EMA may already be HIV-infected, setting the stage for a continuing health crisis that will impact the future of our region for decades to come.** By contrast, less than **0.4%** of heterosexual men are estimated to be HIV-infected in the San Francisco EMA.

Underrepresented Populations in the Ryan White System: Compared to their proportion of HIV/AIDS cases, **women, persons of color, heterosexuals,** and **transgender people** are **over-represented** in the local Ryan White-funded system, while **whites** and **men** are **underrepresented** in the system of Ryan White-funded services, almost certainly because of higher incomes and higher rates of private insurance among the latter two groups. Possibly for the same reason, MSM are underrepresented among Ryan White clients, although they are still the vast majority of clients served at **71.6%**. Ryan White clinics provide primary medical care to a population that is disproportionately made up of persons of color, women, persons with low incomes, the homeless, heterosexuals, and injection drug users. At the same time, Part D programs operated by Larkin Street Youth Services and the Family Service Network primarily serve young people and women, while Part C programs operated by the San Francisco Clinic Consortium and Tenderloin Health serve the full spectrum of clients, including the homeless, persons of color, women, and gay/bisexual men. **Twenty-one percent** of Ryan White clients in the San Francisco EMA are African American as compared to **15.0%** of all persons with HIV/AIDS in the EMA, while San Francisco's seven **Centers of Excellence** – focusing on reaching underserved and hard-to-reach populations – serve a population that is **30.6%** African American.[107] Women are well served by Ryan White, with **12.3%** of Ryan White and **21.7%** of Centers of Excellence clients being women, despite representing **6.2%** of the PLWHA population. Heterosexuals represent **13.6%** of Ryan White clients but only **2.9%** of non-IDU HIV cases. Transgendered people make up an estimated **3.6%** of persons served through the Ryan White system and **5.4%** of persons served through Centers of Excellence while making up **1.8%** of all persons living with HIV and AIDS in the EMA. **These statistics highlight the progress our EMA has made over the past three years in reaching and bringing into care the most impoverished and highly underserved HIV-infected residents of our region.**

EMA Service Gaps: According to the recently completed 2008 Unmet Need Framework (see Section 1.g below), a total of **4,722** HIV-aware individuals in the San Francisco EMA are currently **not** receiving HIV primary care, representing **22%** of the region's total estimated HIV-aware population. Another **2,140** persons with HIV or AIDS are believed to be **unaware** of their status, and are therefore also not receiving HIV care. This means that an estimated **6,862** persons living with HIV/AIDS - roughly **28.8%** of the EMA's combined PLWHA population - are out of care. During the previous 2007-2008 Part A contract period, at least **6,571** individuals were receiving Ryan White-funded services in the EMA, representing roughly **40%** of the region's combined PLWHA population in care, and **28%** of the overall PLWHA population.

In 2008, the San Francisco EMA commissioned and completed a new **HIV Health Services Needs Assessment**, which included in-depth client surveys completed by **248** PLWHA in all three counties and a series of **4** population-specific focus groups involving monolingual Spanish-speaking persons; persons age 55 and older; Marin County residents; and formerly incarcerated individuals.[108] The Needs Assessment was instrumental in

guiding FY 2009 prioritization and funding allocation decisions by the San Francisco HIV Health Services Planning Council. **The Needs Assessment revealed that the local system of care was extremely successful in meeting HRSA core service needs among HIV-infected persons who have low incomes, with fully 95% of survey respondents reporting that their last health care visit for HIV/AIDS had been within the past six months.** While the majority of needs assessment respondents stated that they were able to access needed care services, challenges and barriers to health and supportive services that respondents "always" or "sometimes" experience included: a) **transportation** (**12.7%** always / **30.5%** sometimes); b) **service hours** (**6.8%** always / **35.0%** sometimes); c) **cultural sensitivity** (**3.8%** always / **15.3%** sometimes); and d) **language** (**3.0%** always / **9.7%** sometimes). In regard to housing, **21%** of survey respondents met the criteria for being **homeless -** including **4%** living on the streets or in a car - while **12%** of respondents do not have health coverage of any kind.

HIV Prevention Needs

The need for consistent, personalized, and assertive HIV prevention education and support for persons living with HIV and AIDS is being increasingly recognized and affirmed as an indispensable component in any effective system of HIV care. The US Centers for Disease Control and Prevention's *Advancing HIV Prevention (AHP)* Initiative highlights prevention with positives as the **third** of the initiative's four central strategies, stressing the importance of prevention with positives programs in reaching those who have been diagnosed with HIV but are not in care, and emphasizing the need to develop standardized procedures for prevention interventions for persons living with HIV.[109]

The San Francisco EMA has been at the forefront of efforts to develop and incorporate effective HIV prevention approaches within care and treatment programs, and has worked for many years to develop collaborative approaches that link HIV care and prevention on a broad range of levels. For example, the San Francisco HIV Health Services Planning Council has for several years sponsored regular collaboration meetings and a "Points of Integration" Committee with the San Francisco HIV Prevention Planning Council in order to formulate collaborative programs, ensure effective and prompt linkages between HIV testing and treatment, and incorporate HIV prevention expertise into the design and implementation of prevention with positives services in HIV care agencies. The Planning Council has also consistently supported and endorsed programs within HIV service agencies that train providers to offer HIV prevention education, counseling, and support, and that incorporate HIV prevention support groups, activities, and workshops into their existing range of HIV services. The EMA's new Centers of Excellence program also incorporates prevention with positives as a key element in helping retain severe need populations in care on a long-term basis.

In an effort to more clearly determine additional needs for prevention with positives programs, the 2005 Comprehensive HIV/AIDS Needs Assessment included a new series of questions regarding the quantity and scope of prevention with positives information and

support that respondents received from a range of HIV service providers in the San Francisco EMA. The questions revealed that the majority of respondents had received prevention-related information on a range of topics from medical care providers, case managers and social workers, and health educators, counselors, and substance use treatment counselors. However, the questionnaire also revealed significant gaps in HIV prevention for positives which the EMA must address. For example, fewer than 50% of respondents reported receiving any HIV prevention information from peer advocates, outreach workers, or alternative therapists such as acupuncturists and herbalists. The need for expanding prevention with positives education and support at all levels of HIV care will be a critical priority that will continue to be addressed by the Planning Council over the coming three years.

F. DESCRIPTION OF THE CURRENT CONTINUUM OF CARE

The San Francisco EMA has a long and distinguished history of responding to the HIV crisis with a comprehensive continuum of service programs that are impactful, innovative, sensitive, and cost-effective. During the first decade of the AIDS epidemic, when San Francisco was the city hardest-hit by the AIDS crisis, our region developed a comprehensive network of services that utilized **case management** to link individuals to medical and supportive services. This system became known as the **"San Francisco Model of Care"** and had a lasting impact on the organization of HIV services in the US. Over the past decade and a half, the EMA has continued to evolve and grow to respond to changes in the epidemic and its affected populations, while incorporating new treatment developments. In the mid-1990s, as the epidemic had an increasing effect on disenfranchised individuals, San Francisco developed the **Integrated Services Program,** a multidisciplinary approach to care in which HIV services were merged, coordinated, and linked to stabilize and retain hard-to-reach and severely affected individuals. This approach has culminated in a dramatic intensification of the integrated services model in the form of the EMA's seven **Centers of Excellence -** programs that are offering a new approach to stabilizing the lives of multiply diagnosed and severe need populations through neighborhood-based, multi-service centers tailored to the needs of specific cultural, linguistic, and behavioral groups.

However, as San Francisco continues to cope with a dramatic fiscal and economic crisis affecting our state and region, six consecutive years of Part A funding reductions – reductions based not on grant applications, which have been well received, but on legislated formulas - have presented our EMA with serious threats to the survival of what began as the San Francisco Model of Care. The growing funding crisis threatens our EMA's ability to continue serving all persons with HIV, and sets the stage for a greater crisis in the future as more individuals with more complex needs seek treatment for HIV. The San Francisco EMA has struggled to provide the highest quality and most comprehensive services possible for Ryan White-eligible populations throughout this crisis, while coping with the demands of an expanding HIV-infected caseload, rising health care costs, and a population that is progressively more impoverished and in need of supportive services. Today, despite our diligent efforts to implement more cost-effective service models, our ability to continue saving lives and reducing the costs of catastrophic and emergency care is in serious jeopardy.

Throughout the San Francisco EMA, the emphasis on **high-quality, client-centered, and culturally competent primary medical care services** remains at the heart of our care continuum, with both **medical and non-medical case management** offering individualized assessment, coordination, and linkage to a full range of complementary social and supportive services. In addition to a number of major hospitals in the EMA, there are **seven** public clinics and **six** community clinics in San Francisco County; **two** public clinics in San Mateo County; and **one** public clinic in Marin County providing HIV/AIDS primary care. In Marin County, cases and services are focused around the major cities

bordering the north-south-running Highway 101. San Mateo County has one HIV epicenter along its border with San Francisco and another at the opposite end of the county adjacent to East Palo Alto, with services spread between them. All non-medical Ryan White-funded providers throughout the EMA are trained to refer persons with HIV to **any** primary care site in the region.

In addition to medical care, the local continuum of care encompasses a range of **linked programs** that help people access and remain in treatment in the face of daunting life challenges. These services include case management, mental health and substance abuse treatment, dental care, treatment adherence support, direct emergency financial assistance, food, benefits counseling, and housing. The local continuum also includes access to critical services such as home health care and adult day health care to help persons living with HIV cope with more complex medical needs, while helping facilitate access to medical care through services such as transportation and childcare. A range of ancillary services such as money management support and legal and immigration assistance helps clients better manage the circumstances of their lives to consistently access treatment. Inpatient care is provided in a range of settings, most funded through non-Part A sources. A comprehensive matrix of HIV prevention, counseling, testing, early intervention, and care linkage services are supported through non-Part A funding streams, many directly linked to the new Centers of Excellence.

The primary challenge of Part A-funded agencies in the current environment is to stabilize peoples' lives so that they can access care on a more consistent basis, while continuing to provide comprehensive, quality care for those whose lives remain chaotic. An increasingly large proportion of those affected by HIV in our region are members of **emerging and multiply diagnosed populations** who face a broad range of co-morbidities such as homelessness, poverty, mental illness, substance addiction, recent incarceration, and/or a range of additional health and life complications, including the effects of aging with HIV. San Francisco's integrated services programs have been highly successful in bringing such hard-to-reach clients into care and helping them manage their medications and remain in the system on a long-term basis. However, many programs providing specialized support services focused on hard-to-reach populations have been **de-funded** as a result of Part A funding cuts in our EMA from FY 2003 through FY 2008 - cuts made just at the time when those services are most urgently needed.

The San Francisco EMA operates a wide range of outreach, care linkage, and treatment access activities to reach severe need populations, some of them supported through **MAI funding**. Marin County, for example, has co-located testing, primary care, social services, and research programs in one central facility to provide easier access to service for residents, while the San Francisco HIV Prevention section has funded a new full-time linkage specialist to concentrate on linking newly tested positive persons with counseling and care. San Mateo's Health Outreach Team travels throughout the county providing outreach, peer support, triage, referrals, and transportation to appointments. The emphasis of all of these programs is on ensuring that disenfranchised and underserved

HIV-infected persons learn about their HIV status; become informed about the system of care; and receive the support they need to access services on a long-term basis.

Additional Part A-funded components of the system of care increase clients' ability to access service and increase their comfort level with regard to medical care and drug treatment. Substance abuse and mental health services, for example, improve clients' emotional and physical well-being, improve stability, and increase the chances of long-term treatment adherence. Benefits counseling maximizes access to health insurance and other income streams, while money management helps persons with HIV living on low incomes maintain housing and other essential services. Childcare assists families - particularly those headed by women - in accessing medical and other services, while transportation via van service and bus and taxi tokens enables clients to access health care appointments. All of these services play an essential role in allowing people to access and remain in care over the long term.

One of the most important ways of ensuring entry and retention in care is by providing **culturally competent** services that are comfortable and accessible, and that allow consumers to feel respected, understood, and accepted. Our EMA is one of the most ethnically and culturally diverse regions in the nation, and local services have evolved to respond to the specific ethnic and cultural characteristics of our clients by ensuring that care is provided in welcoming and culturally appropriate environments. Community of color organizations provide culturally-centered care for a broad range of populations, particularly in the city's hard hit African American, Latino, and Asian communities, offering tailored services such as substance abuse treatment for monolingual HIV-positive Spanish speaking clients. Agencies such as the Asian Pacific Islander Wellness Center, the Black Coalition on AIDS, Instituto Familiar de la Raza, Mission Neighborhood Health Center, the Native American AIDS Project, and the Native American Health Center all maintain Part A contracts and subcontracts to provide care to persons of color in our region.

A primary goal of our Centers of Excellence system has been to specifically draw in and maintain higher percentages of severe need persons of color in treatment. To determine our success in reaching this goal, San Francisco HIV Health Services in 2008 commissioned a detailed analysis of the Centers of Excellence program, in part to compare CoE service populations with those of the Ryan White system as a whole. **Among other findings, the analysis discovered that while persons of color make up 52.7% of the total Ryan White service population in the EMA, they made up fully 71.0% of all Centers of Excellence clients, including a population that is 30.6% African American and 19.6% Latino/Hispanic.**[110] The analysis also discovered that the Centers of Excellence were serving a significantly **younger** population than that served by the Ryan White system as a whole, and that the Centers were serving **over 50% more transgender clients** than the system as a whole (**5.3%** of CoE clients versus **3.4%** of systemwide clients).

The San Francisco EMA's new Centers of Excellence (CoE) network has successfully forged a new type of "safety net" for severe need and special populations, one that encompasses a range of population and neighborhood emphases and that has begun to make a major contribution to our EMA's goal of reducing disparities and improving access to care for hard-hit and underserved communities. Through the CoE program, the **Mission Center of Excellence**, **Native American Center of Excellence**, and **Southeast Partnership for Health** provide culturally competent services for **three** key hard-hit populations of color in our region: Latinos/Hispanics, Native Americans, and African Americans, respectively. Meanwhile, the **Women's Center of Excellence** provides a unique range of services specifically tailored to the needs of HIV-positive women, while the **Tenderloin Area Center of Excellence** offers services to homeless and marginally housed individuals, as well as active substance users, transgender persons, and - through a partnership with Asian Pacific Islander Wellness Center - Asian/Pacific Islander communities. The services of the **Forensic AIDS Project** provide unique incarceration-based outreach, service, and post-release follow-up to persons in San Francisco County Jails, while the **Tenderloin Center** operates an outreach and linkage program within our region's three state prisons. All CoEs also incorporate prevention with positives interventions (PWP) into their care regimens and are fully linked to the regional HIV counseling and testing network. The **Women's Centers of Excellence**, for example, incorporates an innovative PWP program for women and male-to-female transgender people called the **Sexual Health and Empowerment Program (SHE)**, an intervention incorporating formal risk assessments; one-on-one counseling with on-site Prevention Coordination; and ongoing risk-reduction groups and other services, including sexual and IVDU harm reduction seminars, support, and referrals. The chart below outlines the names and functions of the seven CoEs now operating in our EMA (see Figure 15.

Figure 15. Chart of San Francisco EMA Centers of Excellence (CoEs)

Name of CoE	Lead Agency	Location(s)	Target Populations
Chronic Care HIV/AIDS Multidisciplinary Program Center of Excellence (CCHAMP CoE)	University of California San Francisco	Mission / Potrero Hill District (San Francisco General Hospital) &. Clinics in South of Market, Upper Van Ness, & Castro	MSM, Latino, African American, transgender, women, persons 50 years and over, immigrants & undocumented, Spanish-speaking
Forensic AIDS Project	San Francisco Department of Public Health	Five San Francisco County Jails with an average daily census of 2,200 prisoners	Coordinating HIV-positive care for incarcerated people both in jail and post-release
Mission Center of Excellence	Mission Neighborhood Health Center	Mission District	Focus on Latino/Latina populations, including monolingual Spanish speakers, immigrants & undocumented

Name of CoE	Lead Agency	Location(s)	Target Populations
Native American Center of Excellence	Native American Health Center	Medical care in Mission District / Additional services in Potrero Hill	Focus on Native Americans and Alaska Natives, including male, female, & transgender
Southeast Partnership for Health	Westside Mental Health Center	Bayview / Hunters Point & Western Addition	Focus on underserved & severe need African American populations
Tenderloin Area Center of Excellence	Tenderloin Health	The Tenderloin	Homeless & marginally housed, active substance users, transgender people, Asian/Pacific Islander groups, prison populations
Women's Center of Excellence	University of California San Francisco	Medical care in Mission District & Parnassus / Additional services in Upper Van Ness & Western Addition	Underserved and severe need women

In addition to the CoE program, Minority AIDS Initiative funds continue to have a major impact on the San Francisco EMA, allowing us to identify, reach, and bring into care a significant number of highly disadvantaged persons of color, in turn reducing service disparities and improving health outcomes across our region. During Fiscal Year 2008, MAI funds have been used to support outreach, treatment adherence, and case management programs targeted to populations most underserved by existing programs, with a focus on Latino communities and women of color. Meanwhile, treatment adherence services target transgender women of color, Latinos, and Asians & Pacific Islanders. MAI-funded peer and treatment advocates help clients make informed decisions about medications, and work with them to identify and remove barriers to adherence. MAI-funded transitional case managers have been especially successful at connecting **incarcerated PLWHA of color** to primary medical care services. MAI-funded case managers meet repeatedly with HIV-infected clients of color within prison settings, preparing a collaborative post-release plan that allows clients to transition into culturally appropriate services once they are released.

F. RESOURCE INVENTORY &
G. PROFILE OF CARE-ACT FUNDED PROVIDERS

The chart that begins on the following page provides a comprehensive listing of agencies in the San Francisco EMA that provide direct care and support services for persons in our region who are infected and affected by HIV and AIDS. Together, these agencies make up a high-quality continuum of care that is designed to provide the most effective and sensitive levels of treatment, support, and prevention services, while offering a high degree of cost-effectiveness and coordination.

The chart also specifically indicates the agencies in our EMA that receive direct funding through Ryan White Part A, Part B, Part C, Part D, and HOPWA sources. The San Francisco EMA is dedicated to ensuring the integration and coordination of **all** sources of Ryan White funding in our region. The San Francisco HIV Health Services Planning Council prioritizes the use of Ryan White funds for services that are not adequately funded through other reimbursement streams in order to ensure that Part A funds are the funding source of last resort. During each year's priority setting and allocation process, the Grantee produces detailed fact sheets on each service category that include a listing of **all** other funding streams available for that category, including Part B, C, D, & F programs and MAI funding. The San Francisco Planning Council also serves as the Part B Consortium for its region, and plans Parts A and B services **concurrently**. The Planning Council also works with local planning groups such as the HIV Prevention Planning Council and the Substance Abuse Treatment on Demand Planning Council to coordinate services and eliminate duplication. The figure below details the complementary Ryan White contributions received throughout the San Francisco EMA during the most recent 12-month contract period (see Figure 16).

Figure 16. Complementary Ryan White Funding – San Francisco EMA
Most Recently Completed 12-Month Funding Cycles

Local Jurisdictions	Ryan White Funding Categories & Amounts				
	MAI	Part B	Part C	Part D	Part F
San Francisco County	$641,576	$1,596,792	$1,255,713	$1,041,057	$1,913,249
San Mateo County	0	$8,336	0	0	0
Marin County	0	0	0	0	0
TOTAL	$641,576	$1,605,128	$1,255,713	$1,041,057	$1,913,249

SAN FRANCISCO, CALIFORNIA EMA
INVENTORY OF HIV SERVICE AGENCIES AND RESOURCES

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
AIDS Community Research Consortium 1048 El Camino Real Redwood City, CA 94063	Client Advocacy and HIV Treatment Adherence Services targeted to the monolingual and bi-lingual Spanish-speaking in San Mateo County	**X**			
AIDS Emergency Fund 965 Mission Street, Suite 630 San Francisco, CA 94103	Financial assistance to persons with AIDS and disabling HIV to support housing, phone costs, utilities, and certain medical expenses.	**X**			
AIDS Health Care Foundation "Magic Johnson" Clinic 1025 Howard Street San Francisco, CA 94103	HIV adult primary care, including testing and treatment for HIV, tuberculosis, other STDs, and adult immunizations for clients; psychological services; HIV, STD and general health education; HIV, STD prevention, and outreach programs				
AIDS Housing Alliance – San Francisco 427 South Van Ness Avenue San Francisco, CA 94103	Housing referral and advocacy program for persons with HIV and AIDS. Provides apartment listings, deposit assistance, tenant's rights counseling, and advocacy.				
AIDS Legal Referral Panel 1663 Mission Street, Suite 500 San Francisco, CA 94103	Free or low-cost legal services and education for persons with HIV/AIDS.	**X**			
AIDS / HIV Nightline **(San Francisco Suicide Prevention)** P.O. Box 191350 San Francisco, CA 94119	Toll-free, volunteer, all-night telephone service providing emotional support, crisis intervention, and referrals in English and Spanish.	**X**			

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
American College of Traditional Chinese Medicine ACTCM Community Clinics 450 Connecticut Street San Francisco, CA 94107	Community clinic providing traditional Chinese medicine, including acupuncture, herbal therapy, nutritional counseling, Tui Na (Chinese medical massage), Qigong, cupping, moxibustion, and electro-stimulation. Services also accessible through Castro Mission Health Center, Maxine Hall Health Center, Mission Neighborhood Health Center and Haight Ashbury Free Medical Clinic.				
Ark of Refuge, Inc. 1025 Howard Street San Francisco, CA 94103	HIV prevention education, case management, medical services, HIV housing, substance abuse, multiple session groups, youth and individual counseling, homeless and hunger prevention.	**X**			
Asian & Pacific Islander Wellness Center 730 Polk Street, 4th Floor San Francisco, CA 94109	Health prevention education, early intervention, case management, client advocacy, and referrals to Asians / Pacific Islanders at risk for or living with HIV/AIDS.	**X**			
Asian Women's Shelter 3543 18th St. #9 San Francisco, CA 94110	Shelter, case management, counseling, food, clothing and support services, queer Asian women's services, 24 hour domestic violence crisis line.				
Aurora Dawn Foundation **Marty's Place** 1167 Treat Avenue San Francisco, CA 94110	11-bed, subsidized, long-term home in the Mission District for homeless, low-income HIV positive men, including access to ancillary services				
Baker Places, Inc. 600 Townsend Street San Francisco, CA 94107	Residential Detox and Substance Abuse services for adults living with HIV infection who are very low income and uninsured or underinsured.	**X**			

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Bar Association of San Francisco Volunteer Legal Services Program 1360 Mission Street #201 San Francisco, CA 94103	Free legal counseling for homeless persons or those at serious risk for becoming homeless, including phone counseling during business hours and benefits advocacy with focus on benefits related to mental disabilities.				
Bay Area Addiction Research and Treatment, Inc 1111 Market Street San Francisco, CA 94103	Methadone maintenance and detoxification services, outpatient primary care including comprehensive physical examination and lab work, health monitoring and management, toxicology screening for recovery monitoring, medication, and prescriptions and management, drug counseling/psychotherapy, STD and hepatitis testing, vocational/educational counseling, case management, self-help modalities education and referral services				
Bay Area Women's and Children's Shelter 318 Leavenworth St. San Francisco, CA 94102	Information and referrals, healthcare, clothing, employment services, parent/child program.				
Bay Area Young Positives 701 Oak Street San Francisco, CA 94117	Peer-based emotional support, educational workshops, and social events for HIV positive individuals, support groups, HIV treatment advocacy, health education, and risk reduction counseling, on-site HIV testing and counseling, Speakers Bureau, outreach services				
The Bayview Hunters Point Foundation for Community Improvement, Inc. 5815 Third Street San Francisco, CA 94124	Legal services, mental health and substance abuse treatment, youth services, violence prevention / intervention, support services.				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Black Coalition on AIDS (BCA) 2800 Third Street San Francisco, CA 94017	HIV prevention and education for HIV-positive and HIV-negative individuals, Many Men, Many Voices program for gay black men, case management and referral, benefits counseling, transitional housing,				
California Department of Rehabilitation China Basin Office 301 Howard Street-7th floor San Francisco, CA 94105	Vocational counseling and evaluation, job training and placement for people, resume development and interview techniques instruction, post employment services, medical and transportation support, financial assistance for higher education costs, reader, interpreter, and note taker services, independent living skills instruction				
California Pacific Medical Center Pacific Campus 2333 Buchanan Street San Francisco, CA 94120	Case management services, comprehensive health and medical care services, complementary care (alternative medicine), inpatient and outpatient psychiatric care, physical rehabilitation, vision care, outpatient IV therapy and HIV/AIDS care, HIV testing, STD testing and treatment				
Castro Mission Health Center (SFDPH) 3850 17th St. San Francisco, CA 94114	Primary and preventive health care. Women's and family clinics by appointment.	**X**			
Catholic Charities of the Archdiocese of San Francisco 180 Howard Street San Francisco, CA 94105	Various locations throughout San Francisco to provide assisted housing services, attendant care within a hospice environment, and residential substance abuse services for women and their children.	**X**			**X**

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Catholic Charities of the Archdiocese of San Francisco – Guerrero House 899 Guerrero St. San Francisco, CA 94110	20-bed transitional living program for homeless youth 18-23. Housing, meals, case management, counseling, life skills training.				
Center for Special Problems (SFDPH) 1700 Jackson St. San Francisco, CA 94109	Individual, couple and group counseling, including offender services for those in the criminal justice system. Services for victims of physical and sexual abuse. Services for LGBT. Medication and HIV counseling.	**X**			
Central City Hospitality House Tenderloin Self-Help Center 290 Turk Street San Francisco, CA 94102	Services to meet immediate needs of homeless persons including case management, clothing vouchers, food vouchers, telephone and bathroom facilities, support groups, and other services				
Chinatown Public Health Center (SFDPH) 1490 Mason St. San Francisco, CA 94133	Health education, nutrition counseling, public health nursing. Primary care services, prenatal and family planning, referrals for mental health, children's dental care.				
Cole Street Youth Clinic 555 Cole St. San Francisco, CA 94117	Case management, therapy, medical care, health education and prevention services, crisis intervention, group and one-on-one intervention and counseling.				
Coming Home Hospice Residence 115 Diamond Street San Francisco, CA 94114	15-bed congregate living health facility for individuals with AIDS, cancer, and other terminal illness, including 24-hour care through registered nurses, licensed vocational nurses, attendants, chaplains, social workers and volunteers, meals, laundry services, and recreation therapy				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Community Awareness & Treatment Services 1446 Market Street San Francisco, CA 94102	Residential Substance Abuse and Mental Health Counseling services for low-income men and women living with HIV/AIDS.	**X**			
Community United Against Violence 170-A Capp Street San Francisco, CA 94110	Addresses issues and advocates for prevention of violence directed at lesbian, gay, bisexual, transgender, queer, and questioning persons, including crisis intervention, short-term counseling, and assistance with the criminal justice system, support groups, 24-hour crisis line				
Compass Community Services 49 Powell Street 3rd Floor San Francisco, CA 94102	Emergency food, housing, counseling, transportation, and child care to help stabilize and secure permanent housing, entitlement benefits, and employment for families with children who are homeless or at risk of being homeless, including two-year transitional housing program for families with intensive rehabilitative needs				
Conard House, Incorporated **Conard House Community Services North** 501 Ellis Street San Francisco, CA 94102	Money management and case management services, assists SSI/SSA recipients with locating and maintaining stable housing, representative payee; budgeting assistance; and advocacy services, assistance with securing food, clothing and other daily living needs, ongoing supportive contact and assistance with crisis situations.				
Daly City Youth Health Center 2780 Junipero Serra Blvd Daly City, CA 94015	Medical care, mental health counseling, vocational counseling and mentoring, referrals and support groups.				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Delancey Street Foundation, Inc. 600 Embarcadero San Francisco, CA 94107	Residential services for substance abusers, ex-prisoners, individuals with social adjustment problems. Employment training.				
Department of Human Services California Work Opportunity and Responding to Kids (CALWORKS) 170 Otis Street San Francisco, CA 94103	Financial assistance for the care of children when one or both parents are absent, disabled, deceased, or unemployed, job search and training, vocational education, child care, transportation, Medi-Cal assistance, Food Stamps for eligible family units, up to 16 days of funding for temporary housing for homeless families, translation services in Spanish, Chinese, Vietnamese, and Russian				
Department of Public Health - San Francisco City Clinic 356 Seventh Street San Francisco, CA 94103	STD prevention & control including comprehensive confidential STD examination, diagnosis, treatment and risk reduction/prevention counseling services, Hepatitis A & B vaccinations, confidential HIV testing, HIV risk reduction counseling; partner notification services; early care services for HIV positive patients and their partners, ADAP enrollment, post-exposure prophylaxis (PEP) for anyone exposed to HIV within the last 72 hours				
Dimensions at Castro Mission Health Center (SFDPH) 1757 17th St. San Francisco, CA 94114	Primary medical care, mental health services, case management, family planning, peer support, counseling, referrals, health education, substance abuse counseling, HIV testing.				
Dolores Street Community Services – The Cohen House 938 Valencia Street San Francisco, CA 94110	Assisted living residence for formerly homeless men and women living with HIV/AIDS, including shelter outreach in English and Spanish.	**X**			**X**

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
El Concilio of San Mateo County 1419 Burlingame Avenue, Suite N Burlingame, CA 94010	Outreach, education and prevention, support groups, substance-abuse education and referrals.				
Ellipse Peninsula AIDS Services 173 South Boulevard San Mateo, CA 94402	Information and referrals, groceries and nutritional supplements.				
Episcopal Community Services of San Francisco - Episcopal Sanctuary 201 8th Street San Francisco, CA 94103	Overnight shelter for homeless individuals on a daily basis for a period of 30 days renewable on a case by case basis, case management, a medical clinic, shower facilities, breakfast and dinner during shelter hours, ESL, computer, US citizenship, GED, and life skills training, voice mailboxes for homeless clients seeking jobs				
Episcopal Community Services of San Francisco - Next Door 1001 Polk St. San Francisco, CA 94109	Transitional housing (up to six months) for homeless adults. Case management, substance abuse and mental health counseling, educational services.				
Family Link 317 Castro Street San Francisco, CA 94114-1504	Guest accommodations in a supportive environment for family members of people with disabling AIDS or other critical illness who require temporary living arrangements while visiting from outside of San Francisco				
Family Service Agency of San Francisco 1010 Gough St. San Francisco, CA 94109	Support, education and counseling to parents. Mental health services, support re substance abuse, child abuse issues. Teen parenting/pregnancy program.	**X**			

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Family Violence Project (San Francisco District Attorney Department) 850 Bryant St., Rm. 320 San Francisco, CA 94103	Legal advocacy, referrals, information.				
Forensic AIDS Project (SFDPH) 798 Brannan, 2nd floor San Francisco, CA 94103	Primary care, case management and release-related referrals for inmates in the San Francisco County Jail system living with HIV/AIDS.	**X**			
General Assistance Advocacy Project 276 Golden Gate Avenue San Francisco, CA 94102	Assistance, information, and referrals for individuals applying for or experiencing difficulties concerning CAAP and Food Stamps and Supplemental Security Income (SSI) through law school students and community volunteers				
Glide Extended Family Recovery Program 330 Ellis St., Ste. 105 San Francisco, CA 94102	Meals, social services, cultural programs, computer training, drug counseling, job placement, women's drop-in center. Temporary shelter referrals, clothing, basic necessities.				
Glide Health Clinic 330 Ellis St., Ste. 418 San Francisco, CA 94102	Primary and urgent care, mental health, complementary care (massage, acupuncture, energy work), podiatry services, referrals for dental and vision care.				
Guerrero House 899 Guerrero St. San Francisco, CA 94110	20-bed transitional living program for homeless youth 18-23. Housing, meals, case management, counseling, life skills training.				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Haight Ashbury Free Medical Clinic 558 Clayton St. San Francisco, CA 94117	Primary medical care, referrals, condom and bleach distribution, podiatry, chiropractic and acupuncture. Youth Outreach Center provides HIV prevention education, hepatitis and overdose prevention, crisis intervention, showers, clothing, snacks, outreach to homeless/runaway youth, and referrals for medical care, detox, and counseling for injection drug users.	**X**	**X**		
Hamilton Family Center 1631 Hayes Street San Francisco, CA 94117	30-day, 24 hour emergency homeless shelter for up to 70 family residents including single parents, expectant couples, same-sex couples with children, and pregnant women, including meals, medical and prenatal care, housing referrals, employment counseling; referrals to social services, case management, on-site afterschool learning center				
Healing Waters 167 Fell Street San Francisco, CA 94102-5106	Outdoor trips specifically for people with HIV and AIDS				
Health at Home (SFDPH) 45 Onondaga San Francisco, CA 94112	Provision of comprehensive multi-disciplinary home health care services to people living with HIV/AIDS allowing them to continue living independently at home and avoid institutionalization. Services include skilled, intermittent care as well as palliative and end-of-life care.	**X**			
Health Initiatives for Youth (HIFY) 235 Montgomery Street, Suite 430 San Francisco, CA 94104	Youth-specific health workshops, trainings, and events, publications and resource materials, youth-specific HIV prevention interventions, youth-related health services planning support.				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
HIV Care at St. Francis Memorial Hospital 900 Hyde Street, Room 406 San Francisco, CA 94109	Supports clinical trials of promising HIV/AIDS treatments through the clinical research clearinghouse of the HIVCare newsletter.				
Hospice of Marin by the Bay 17 East Sir Francis Drake Blvd. Larkspur, CA 94939	Nursing case management, skilled nursing, and coordination of attendant care services to disabled PLWH. Medi-Cal waiver program	**X**			
Huckleberry Youth Services 555 Cole Street San Francisco, CA 94117	Community-based adolescent health clinic providing comprehensive health and social services including STD screening and treatment, management of chronic health problems, confidential HIV testing, case management and psychosocial services, crisis intervention, therapy, prevention/education services to address high risk behaviors				
Immune Enhancement Project 3450 16th Street San Francisco, CA 94114	Complementary and alternative medical services, including acupuncture, therapeutic massage, herbal therapy, and nutritional counseling.	**X**			
Independent Living Resource Center 649 Mission Street San Francisco, CA 94105	Services to assist disabled individuals to live independently including benefits counseling/advocacy, peer counseling, peer counseling training and support groups, and self-advocacy workshops				
Instituto Familiar de la Raza 2919 Mission Street San Francisco, CA 94110	HIV Mental Health services and Case Management for monolingual and bilingual Spanish speaking clients in San Francisco.	**X**			
Iris Center 333 Valencia Street, #222 San Francisco, CA 94103	Mental Health Counseling Substance Abuse Recovery services to HIV + women in San Francisco.	**X**			

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Japanese Community Youth Council (JCYC) 2012 Pine St. San Francisco, CA 94115	Counseling, education, job training, substance abuse prevention and intervention, youth leadership development.				
Jewish Family and Children's Services 2150 Post Street San Francisco, CA 94115	HIV services for Jewish individuals and their families, including counseling, case management, information and referral, attendant care, spiritual support, emergency financial assistance				
KAIROS Support for Caregivers 730 Polk Street San Francisco, CA 94109	Resource center for caregivers of individuals affected by a chronic, long-term or terminal illness, including HIV/AIDS and cancer				
Kaiser Permanente Medical Center San Francisco - Kaiser Permanente HIV Services 2425 Geary Boulevard #L140 San Francisco, CA 34115	HIV supportive services for Kaiser members, including ADAP enrollment, benefits, disability and financial assistance, chemical dependency recovery program for HIV positive individuals and gay men, nutritional counseling and medication hotline, Positive Self-Management Program (PSMP) which teaches problem-solving skills; support groups, clinical trials, and social services				
La Casa de Las Madres 1850 Mission St., Ste. #8 San Francisco, CA 94103	Shelter, support groups, individual counseling for battered women and children. Support groups for teens in abusive or controlling relationships.				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Laguna Honda Hospital and Rehabilitation Center 375 Laguna Honda Boulevard San Francisco, CA 94116-1499	Skilled nursing care facility, including a small general service inpatient acute medical unit specializing in geriatric care, an independent rehabilitation center with both inpatient and outpatient services, skilled nursing care and hospice care for individuals with dementia and individuals with terminal illnesses including AIDS who do not require the services of an acute care hospital				
Larkin Street Youth Services 1044 Larkin St. San Francisco, CA 94109	Case management, shelter, HIV prevention services, multiple session groups, showers, clothing, vocational training, GED workshop, tutoring, outreach, medical care, independent living program.	**X**		**X**	**X**
Latino Commission 301 Grand Avenue, Suite 301 South San Francisco, CA 94080	Residential Substance Abuse services for Monolingual Spanish-speaking Latinos living with HIV/AIDS in San Mateo County.				
Legal Services for Children 1254 Market Street, 3rd. Floor San Francisco, CA 94102	Assisting families affected by HIV/AIDS to stabilize and plan for the future of their children through legal representation, case management, crisis intervention, a family support program and individual counseling.	**X**			
Lutheran Social Services of Northern California - AIDS Financial Services 290 Eighth Street San Francisco, CA 94103	Representative payee and money management services, including budget planning, payment of rent and bills, personal distributions, and advocacy with landlords, rental properties, and other supportive service providers				
Lyon-Martin Women's Health Services 1748 Market St., Ste. 201 San Francisco, CA 94102	Prevention education, family planning, HIV testing, support groups, case management, smoking cessation, primary health care.	**X**	**X**		

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
LYRIC (Lavender Youth Recreation and Information Center) 127 Collingwood St. San Francisco, CA 94114	Discussion groups for LGBT youth. Social/recreational activities, multiple session workshops, HIV prevention education, after-school groups and job training.				
Maitri 401 Duboce Avenue San Francisco, CA 94117	24-hour hospice and skilled nursing services for low-income men and women with AIDS.	**X**			
Marin AIDS Project 910 Irwin Street San Rafael, CA 94901	Case management, benefits counseling, mental health therapy, volunteer services, and coordination of funds for oral health, transportation, and emergency financial assistance with utility and pharmaceuticals expenses. HIV prevention education for HIV-positive and HIV-negative individuals and Hepatitis C Case management	**X**			
Marin Housing Authority 4020 Civic Center Drive San Rafael, CA 94903	Long term rental assistance subsidies for PLWH/A				**X**
Marin Specialty Clinic 3260 Kerner Street San Rafael, CA 94901	HIV adult primary medical care, Hepatitis C adult consultative medical care, HIV medical case management, HIV mental health services	**X**			
Marin Treatment Center 1466 Lincoln Avenue San Rafael, CA 94901	HIV case management, coordination of substance abuse services, drug treatment and counseling, HIV prevention education	**X**			
Maxine Hall Health Center (SFDPH) 1301 Pierce St. San Francisco, CA 94115	Primary care including prenatal care, family planning, immunizations, methadone treatment program, counseling, referrals and education.	**X**			

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Mental Health Association of San Mateo County 2686 Spring Street Redwood City, CA 94063	Housing services to persons with HIV and AIDS, including referrals, emergency and assistance with other housing related expenses.	**X**			**X**
Mission Mental Health Center 111 Potrero Avenue San Francisco, CA 94103	Mental health services primarily to Latinos, gay men, lesbians, and bisexuals, including short and long term psychotherapy, medication support and monitoring, crisis triage-assessment referrals, and case management				
Mission Neighborhood Health Center Clinica Esperanza 240 Shotwell St. San Francisco, CA 94110	Comprehensive outpatient medical services, family planning, teen clinic, obstetrics/gynecology, senior and homeless services. HIV services including education, treatment counseling, multiple session workshops. HIV testing.	**X**	**X**		
Mission Neighborhood Resource Center 165 Capp Street San Francisco, CA 94110	Drop-in respite from the streets offering bathroom access, showers, laundry services and lockers targeting Mission homeless communities and those at risk, in particular Spanish-speaking immigrants, LGBT, women, active drug users and SRO tenants, including intensive bilingual case management and psychosocial support, TB testing, urgent care, abscess treatment, dental referrals, acupuncture and HIV counseling and testing				
Most Holy Redeemer AIDS Support Group 100 Diamond Street San Francisco, CA 94114-2426	Practical and emotional support to those living with AIDS or disabling HIV disease, including spiritual support, in-home assistance, emotional support groups, and a client activities program.				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
National Alliance on Mental Illness, San Francisco Chapter - Mission ACT Program 2712 Mission St. San Francisco, CA 94110	Support, education, medical services, social services, legal help, group outings and referrals for persons with severe mental illness.				
Native American AIDS Project (NAAP) 1540 Market Street Suite 130 San Francisco, CA 94102	HIV case management and prevention case management, treatment advocacy, street-based outreach, risk-reduction workshops, practical and emotional support, mental health services, community events	**X**			
Native American Health Center 160 Capp St. San Francisco, CA 94110	Prevention, primary care, case management and counseling.	**X**	**X**		
New Leaf: Services for Our Community 1853 Market Street San Francisco, CA 94103	Social and supporting services for LGBT populations, including mental health services, substance abuse treatment, social support services, and prevention with positives programs.	**X**			
North East Medical Services 1520 Stockton Street San Francisco, CA 94133	Comprehensive outpatient health services including primary physician care, specialty physician care, nursing, optometry, nutrition, health education, pharmacy, immunizations, family planning, social services, dental care, lab work, and HIV and STD texting and counseling				
North of Market Senior Services 333 Turk St. San Francisco, CA 94102	Primary care, case management, medical follow-up for seniors. Substance abuse counseling, women's outreach center, home visits to homebound seniors, homeless services.				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
North Peninsula Family Alternatives 1486 Huntington Avenue South San Francisco, CA 94080	Counseling and educational programs, emergency services including food, transportation, housing, shelter, information and referrals.				
Ocean Park Health Center (SFDPH) 1351 24th Ave. San Francisco, CA 94122	Primary care for children, adults, and seniors. Immunizations, pregnancy testing/family planning. WIC and supplemental food programs, health screening, home visits.				
OMI Family Center 1701 Ocean Avenue San Francisco, CA 94112	Comprehensive outpatient adult and youth mental health services primarily for the Ocean View-Merced-Ingleside (OMI) community, including screening, evaluation, referral, and urgent care same-day services for severely mentally ill individuals, including TB testing and psychotropic drug clinics				
Pacifica Resource Center 1809 Palmetto Avenue Pacifica, CA 94044	Emergency services including food, transportation, housing, shelter, information and referrals.				
Pets Are Wonderful Support (PAWS) San Francisco 645 Harrison Street Suite 100 San Francisco, CA 94107	Assistance to low-income individuals with a debilitating chronic or terminal illness (including HIV/AIDS) to care for their pets				
Planned Parenthood Golden Gate 815 Eddy St., #200 San Francisco, CA 94111	Comprehensive gynecological services, reproductive and primary care, family planning, HIV and STD testing and prevention, abortion services, prenatal and well baby classes.				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Positive Resource Center 785 Market Street, 10th Floor San Francisco, CA 94103	Comprehensive benefits assistance and employment programs for persons with HIV/AIDS, including employment and vocational rehabilitation planning, counseling, and coordination, and employment related workshops and support groups.	**X**			
Potrero Hill Health Center (SFDPH) 1050 Wisconsin St. San Francisco, CA 94107	Dental care, primary health care, prenatal care.				
Project FOCYS 1670 Amphlett, Suite 115 San Mateo, CA 94402	Youth and family counseling services, referrals, anger management and parent support groups.				
Project Inform 205 13th Street, # 2001 San Francisco, CA 94103	Comprehensive HIV/AIDS treatment education and advocacy, including hotline services, treatment-related publications and guides, and web and print-based bulletins and updates.				
Project Open Hand 730 Polk Street San Francisco, CA 94109	Home-delivered meals, groceries, nutritional counseling.	**X**			
Quan Yin Healing Arts Center 455 Valencia St. San Francisco, CA 94103	Acupuncture, massage and herbal therapy sessions. Qigong classes, HIV/AIDS treatment, women's health, smoking cessation and substance abuse programs.				
Rape Trauma Services 1860 El Camino Real, Suite 301 Burlingame, CA 94010	Crisis intervention, individual counseling, support groups and referrals.				
Rosalie House (Riley Center) 3543 18th St., Ste. 4101 San Francisco, CA 94110	Shelter, advocacy, support services, referrals for battered women and their children.				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Saint Anthony Foundation 105, 107, 111, 121, 135 Golden Gate Ave. San Francisco, CA 94102	Primary medical care. Specialty clinics include podiatry and nutritional counseling. Alcohol and drug programs, women's shelter, employment and senior services, dining room, clothing and furniture.				
Saint Anthony Foundation **Marian Residence for Women** 1171 Mission St. San Francisco, CA 94103	Case management, shelter, meals.				
Saint James Infirmary 1372 Mission St. San Francisco, CA 94103	Primary care, gynecological and urological care. STD/HIV testing and treatment, immunizations. Support groups, food and clothing, multiple session groups, acupuncture, referrals for legal assistance, transportation, child care, housing, substance use.				
Saint Mary's Medical Center **Saint Mary's HIV Services** 2235 Hayes Street, 5th Floor San Francisco, CA 94117	The comprehensive HIV Services Program provides primary and sub-acute care, case management, HIV treatment advocacy, and peer advocacy to persons with HIV infection and related diseases.	**X**			
Saint Vincent de Paul Society **Arlington Residence, Inc** 480 Ellis Street San Francisco, CA 94102	Residential hotel for low-income single individuals, recovering alcohol abusers, recovering drug abusers, and individuals with a dual diagnosis				
Saint Vincent de Paul Society **South of Market Multi Service Center** 525 5th St. San Francisco, CA 94107	Emergency shelter for homeless adult men and women. Educational services, substance abuse and mental health services, counseling, laundry, medical care, showers, clothing				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Salvation Army Harbor Light Center 1275 Harrison Street San Francisco, CA 94103	Continuum of services to persons with alcohol and drug related problems, including an HIV/AIDS specific program that includes primary substance abuse treatment services and recovery home services supplemented by AIDS/HIV counseling, support groups, referrals to community services, benefits assistance, dietary needs assessment and referrals, and emergency transportation services				
San Francisco AIDS Foundation (SFAF) One Sixth Street San Francisco, CA 94103	Case management, client advocacy, housing subsidies, benefits counseling, Hepatitis A and Hepatitis B vaccinations, sterile syringe exchange as an AIDS prevention method	**X**			
San Francisco Community Clinic Consortium 1550 Bryant Street, Suite 450 San Francisco, CA 94103	Management and support of community clinics throughout San Francisco, where patients receive comprehensive HIV medical, counseling, and referral services within their culturally appropriate community – as an alternative to expensive hospital care. Participating clinics have increased their ability to provide a continuum of care for people who are HIV-positive. As a result, community-based HIV care has significantly expanded to communities that are historically under-served and increasingly affected by HIV: people of color, women, injection drug users, the uninsured, and those who are homeless.	**X**	**X**		
San Francisco Dental Society Emergency and Referral Service 2143 Lombard Street San Francisco, CA 94123	Telephone dental referral service providing names and phone numbers of member dentists according to neighborhoods, languages spoken, emergency hours, and Medi-Cal acceptance policies				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
San Francisco Food Bank 900 Pennsylvania Avenue San Francisco, CA 94107	Provision of low-cost and/or donated food and liquid supplements to nonprofit agencies with food programs to meet the complex nutritional needs of clients living with HIV/AIDS	**X**			
San Francisco General Hospital **Early Access Clinic** 1001 Potrero Avenue, 1-M3 San Francisco, CA 94110	Rapid access to medical services for individuals who have tested positive for HIV or have AIDS through the Early Access Clinic, working with each patient to develop an individualized treatment plan while making patients active partners in their care and discussing the risks and benefits of the various treatment options				
San Francisco General Hospital **HIV Assessment & Prevention Service** 1001 Potrero Ave #301 San Francisco, CA 94110	Client-centered HIV risk assessment, counseling, confidential testing, education, and referrals for both inpatients and outpatients at San Francisco General Hospital, with risk assessment encounters including discussion of risk behaviors, education, the development of a risk-reduction plan, referrals, and signed consent for confidential HIV testing				
San Francisco General Hospital **Medical Center (GMC)** 1001 Potrero Ave. San Francisco, CA 94110	Inpatient hospitalization, acute care, outpatient clinics, primary care, specialty clinics. Dental services, abortions, family planning, ambulatory care, psychiatric emergencies.	**X**			

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
San Francisco General Hospital / University of California San Francisco **Positive Health Program – Ward 86** San Francisco General Hospital Medical Center 995 Potrero Avenue Building 80, Ward 86 (Sixth Floor) San Francisco, CA 94110	Comprehensive, interdisciplinary HIV specialist primary medical care services, including social work services, crisis interventions, case management, client advocacy, benefits counseling, and community referrals. Specialty clinics include urgent care, oncology, hematology, dermatology, nutritional counseling, neurology, women's services, pediatric AIDS care and many others.	**X**		**X**	
San Francisco General Hospital **Psychiatric Emergency Services (PES)** 1001 Potrero Avenue San Francisco, CA 94110	Psychiatric emergency services including psychiatric evaluations and crisis stabilization, short-term case management, and referrals to clinics and hospitalization for individuals receiving psychiatric emergency services				
San Francisco General Hospital **Substance Abuse Services** 995 Potrero San Francisco, CA 94110	Outpatient detoxification treatment, with emphasis on treating injection drug users and other substance users through OTOP, with social, psychiatric, and medical services. Maintenance treatment available for individuals with long-term opiate addiction, with a special focus on treating patients with HIV disease, as well as six-month methadone-assisted detoxification for people with HIV disease who are addicted to heroin and other opiates. Harm reduction program for gay, bisexual, transgender, or questioning men who have questions about speed or need help dealing with speed through Stonewall Project.				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
San Francisco Housing Authority 440 Turk Street San Francisco, CA 94102	Provides for nearly 12,000 public housing residents, and 21,000 Section 8 participants in the City of San Francisco. Provides HOPWA-funded tenant-based rental assistance in scattered sites throughout the city to an estimated 275 households per month.				**X**
San Francisco Lesbian, Gay, Bisexual, and Transgender Center 1800 Market Street San Francisco, CA 94102	Programs and services for LGBT people, their friends and families, including economic and workforce development, children, youth and family services, health and wellness services				
San Francisco Paratransit Broker 68 12th St. San Francisco, CA 94103	Provides four modes of transportation for persons who are unable to use public transportation due to disability				
San Francisco Redevelopment Agency 770 Golden Gate Avenue San Francisco, CA 94102	Oversees designated redevelopment areas in the City of San Francisco under the supervision of the Board of Supervisors. Oversees and administers a variety of HOPWA fund disbursements in San Francisco.				**X**
San Francisco Women Against Rape (SF WAR) 3543 18th St., #7 San Francisco, CA 94110	Crisis intervention and legal advocacy for victims/family affected by rape.				
San Mateo County AIDS Program 229 – 39th Avenue San Mateo, CA 94403	Comprehensive, multidisciplinary HIV primary medical care services, including social services, case management, client advocacy, benefits counseling, psychotherapy, alcohol and drug programs, substance abuse treatment and prevention and HIV testing services.	**X**			**X**

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
San Mateo Medical Center Dental Clinic 775 Willow Menlo Park, CA 94025	Dental services for persons with HIV and AIDS.	**X**			
Shanti 730 Polk Street San Francisco, CA 94019	Drop-in center featuring peer and treatment advocacy and case management, social and recreational activities, volunteer services.	**X**			
Shelter Plus Care Program 1440 Harrison Street San Francisco, CA 94103	Rent subsidies for homeless persons with disabilities and their families in connection with supportive services funded from other sources				
Silver Avenue Family Health Center (SFDPH) 1525 Silver Avenue San Francisco, CA 94134	Comprehensive health screening. Women's clinic, family planning (no abortion), pregnancy testing and prenatal care. Home visits. WIC and dental for children.				
Social Security Administration Civic Center Office 939 Market Street San Francisco, CA 94103	Processes claims for all Social Security programs, including retirement (Social Security Retirement Benefits), disability (SSDI), or death (Social Security Survivors Insurance, Social Security Burial Benefits)				
Southeast Health Center (SFDPH) 2401 Keith St. San Francisco, CA 94124	Comprehensive outpatient health care for adults and children. Dental, prenatal care, well baby care, vision, family planning, podiatry, STD/HIV testing and treatment, home visits.				
South of Market Health Center (SOMA Clinic) 551 Minna St. San Francisco, CA 94103	Health education, medical care, dental, podiatry, referrals, counseling, pediatrics, teens and women's clinics. Group luncheon for HIV positive clients each month.	**X**	**X**		

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
St James Infirmary 1372 Mission Street San Francisco, CA 94103	HIV and other STD counseling and testing, peer counseling, psychotherapy, holistic services, transgender hormone therapy, shelter referrals and linkage, needle exchange, harm reduction supplies, training and support groups for sex workers, community outreach, food and clothing exchange				
Stop AIDS Project 2128 15th Street San Francisco, CA 94114	Multi-service HIV prevention agency including Positive Force, a prevention program by and for HIV-positive gay and bisexual men, media campaigns, outreach, and programs for newly-diagnosed individuals				
Swords to Plowshares Veterans' Rights Organization 1060 Howard Street San Francisco, CA 94103	Supportive services for veterans, including legal counseling and referrals, limited court representation, information and referral to related services, representative payee services, advocacy, benefits assistance, individual counseling and referrals for Post-Traumatic Stress Disorder (PTSD); and a transitional housing program for homeless veterans				
TALK Line Family Support Center 1757 Waller St. San Francisco, CA 94117	Talkline for parents living with children, home visits, respite care program, substance abuse services, counseling, economic self-sufficiency program				
Tenderloin AIDS Resource Center (TARC) 183 and 187 Golden Gate Ave. San Francisco, CA 94102	HIV prevention and education, individual and group counseling, mobile van outreach, HIV testing and treatment, multiple session groups, primary care, peer advocacy, case management, legal clinics for transgender.	**X**	**X**		

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Tenderloin Housing Clinic Law Offices 126 Hyde Street 2nd floor San Francisco, CA 94102	Drop-in legal advice related to landlord/tenant disputes for residents of the Tenderloin, South of Market, and residential hotels citywide				
The C.A. L.L. Primrose Center 139 Primrose Road Burlingame, CA 94010	Emergency services including food, housing, transportation, shelter, information and referrals.				
Tom Waddell Clinic 50 Ivy St. San Francisco, CA 94102	Primary medical care, women's services, mental health, transgender clinic and social services.	**X**	**X**		
University of California San Francisco 360: The Positive Care Center at UCSF 400 Parnassus Avenue San Francisco, CA 94143	Health care services for individuals living with HIV/AIDS, including inpatient and outpatient medical evaluation and treatment, medical, nutrition and pharmacy consultation services via telemedicine technology, benefits assistance, referrals, and research protocols	**X**			
University of California San Francisco AIDS Health Center 1855 Folsom Street, Suite 670 San Francisco, CA 94103	Professional psychotherapy, mental health crisis intervention, and support groups, HIV-related substance abuse services, benefits counseling, social programs for HIV-infected and affected populations, education and training for mental health and substance abuse providers, HIV testing.	**X**			
University of California San Francisco AIDS Substance Abuse Program 1930 Market Street San Francisco, CA 94102	Assessments and intervention related to substance abuse for people with HIV or at risk of infection including drug counseling, relapse prevention, case management, support groups, HIV testing				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
University of California San Francisco Men of Color Program at UCSF Positive Health Practice 400 Parnassus Avenue, 4th Floor, Room A-429 San Francisco, CA 94143	Comprehensive, integrated medical and social services for people with HIV, including a women's specialty program, a pediatric AIDS program, and a general men's clinic, including case management, social work services, peer advocacy, and nutritional counseling.	**X**			
University of California San Francisco Mount Zion Medical Center Department of Medicine General Medical Practice 1701 Divisadero Street 5th Floor, Ste. 500 San Francisco, CA 94115-3011	Comprehensive primary medical services on an outpatient basis, confidential HIV testing				
University of California San Francisco School of Dentistry 707 Parnassus Avenue #D-1000 San Francisco, CA 94143	Low-cost comprehensive dental services including children's services and emergency dentistry, orthodontics, pedodontics, periodontics, oral surgery, and prosthodontics				
University of California, San Francisco Women's and Children's Specialty Program 400 Parnassus Avenue San Francisco, CA 94143	Primary medical care for women with HIV (particularly advanced disease), and primary pediatric care for their children (regardless of HIV status), gynecological care, nutritional counseling, psychosocial assessments and support, legal counseling, pediatric care, on-site child care				
University of the Pacific, School of Dentistry 2155 Webster Street San Francisco, CA 94115	Centralized Dental Services for persons with HIV/AIDS	**X**			

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Veterans Affairs Medical Center Comprehensive Homeless Center 401 Third Street San Francisco, CA 94103	Locates and links homeless veterans to services, including the Healthcare for Homeless Veterans program, clinical and behavioral services in a work-focused program through the Compensated Work Therapy (CWT) program, case management, individual and vocational counseling, supportive housing placement and support				
Visual Aid 116 New Montgomery Street #640 San Francisco, CA 94105	Encourages professional Bay Area artists living with life-threatening diseases, to continue their creative work by providing a core of direct services and support programs				
Walden House, Inc. 520 Townsend San Francisco, CA 94103	Residential Substance Abuse and Detox counseling services for low-income persons in San Francisco living with HIV/AIDS.	**X**			
Westside Community Services 1153 Oak Street San Francisco, CA 94103	Mental Health counseling, and home care attendant services for low-income residents living with HIV/AIDS.	**X**			
Woman, Inc. 333 Valencia St., Ste. 251 San Francisco, CA 94103	Support services for battered women. Support groups, counseling, legal and restraining order support.				
Woman's Place 1049 Howard St. San Francisco, CA 94103	Emergency shelter for homeless women. Referrals, counseling and medical information.				
Women and Children's Family Services 2261 Bryant Street San Francisco, CA 94110-2833	Provides residential and outpatient drug treatment for HIV-positive women and their children, including the African American-focused MIA House, the Latina-focused Aviva House, and Pomeroy House which accepts women with children up to the age of twelve.				

Name and address of agency	Services Provided	Part A / B	Part C	Part D	HOPWA
Zen Hospice Project 273 Page Street San Francisco, CA 94102	Organizes programs dedicated to the care of terminally ill individuals including people with AIDS or cancer				

H. BARRIERS TO CARE

The Planning Council and the Grantee agency consistently monitor barriers that impact service access and availability, both through the comprehensive needs assessment process and through ongoing data collection, program monitoring, and client satisfaction surveys. Information on barriers to care is incorporated into service recommendations made to the Planning Council, and the Council continually develops new initiatives and responses to respond to these barriers. The newly instituted Centers of Excellence model, for example, is specifically designed as an approach to reducing barriers to care for severe need and special populations through integrated, multi-faceted treatment and support services that are geared to the specific needs and characteristics of the populations they serve.

During the previous comprehensive planning process, staff of HIV Health Services identified for the Planning Council specific barriers and issues which are currently having an impact on client access to services or on client service utilization, including barriers related to funding issues. An updated summary of these key barriers to care for specific service categories is provided below:

Primary Medical Care:

- Hepatitis C co-infection continuing to stretch core service resources
- Increasing medical complexity of clients, including expanded co-morbidity factors such as long-term HIV infection, long-term use of anti-HIV medications, long-term alcohol and recreational drug use, aging, and drug resistance
- Need for more resources committed to increased staff training in outreach, active case management, and other areas necessary for expanded service integration
- Increase of patients presenting with methamphetamine use
- Need for training, resources, and referrals to substance abuse services related to crystal meth patients arriving for care while they are still under the influence
- Decreasing reimbursements, particularly Medi-Cal
- Increasing costs of providing medical care
- Increasing number of clients ineligible for Medi-Cal due to lack or disability or immigration status
- Growing anecdotal reports of increasing numbers of marginally housed clients
- Ongoing trend toward multiply diagnosed clients, including clients with mental health, substance use, and other co-morbidities

Case Management:

- Clients are increasingly complex, and may need more specialized, intensive case management, possibly including the assertive case management model, which requires more professional-level staff and smaller case loads

- Diminishing availability of case managers in system due to Ryan White funding reductions

Mental Health Services:

- Not all outpatient mental health providers are certified to bill Medi-Cal for services
- Increased use of services by multiply diagnosed clients with more severe and complex needs, and with a need for more intensive and acute services, and for a longer period of time
- No-show rates are relatively high for outpatient mental health appointments
- Medi-Cal reimbursement rates for mental health services are very low
- Some clients are not eligible for Medi-Cal due to immigration status
- Potential cuts impending in the San Francisco Department of Public Health general funds budget for mental health programs
- Decreasing number of volunteers available to work crisis mental health phone lines
- For residential mental health services, providers and caregivers have identified a need for education and training of nursing and attendant care staff regarding the management of cognitively impaired clients
- Continued need for additional residential mental health services and care for long-term survivors as they develop cognitive impairment

Substance Abuse Treatment Services:

- Decreasing Ryan White funding resulting in reduced substance abuse treatment support throughout the San Francisco EMA
- Decrease in public Medi-Cal funding for drug treatment coupled with a new legislative mandate to maintain certain individuals on methadone
- Increasing number of clients with both substance use and mental health issues
- Increasing costs of providing substance abuse treatment services
- Outpatient drug treatment may not always be the most effective modality for serving severe need clients

Housing Programs:

- Population more difficult to serve because of increasing co-morbidities
- Emergency housing program dependent on on-site case manager supported by City of San Francisco general funds
- Insufficient resources for transitional or permanent housing, leading to many individuals returning to the streets when the term of emergency housing ends
- Need for increased emergency housing for families and youth
- Increasing costs of providing housing in the San Francisco EMA

SECTION 2: WHERE DO WE NEED TO GO: WHAT IS OUR VISION OF AN IDEAL SYSTEM?

A. A CONTINUUM OF CARE FOR HIGH QUALITY CORE SERVICES: A SHARED VISION FOR SYSTEM CHANGE

The creation of a fully coordinated system of high-quality, client-centered, and culturally competent care in which <u>all</u> persons with HIV have equal access to the same high level of service and support remains at the heart of the San Francisco EMA's definition of an effective, comprehensive continuum of HIV care. Such a system places a high emphasis on **stabilizing clients' lives** and **meeting basic needs** in order to help people with HIV access and utilize **primary medical care services** on a long-term basis. Our system also includes **integrated services** tailored to the needs of specific populations, and based to the greatest extent possible within **common facilities** that allow clients to more easily access care. The system strives to create a **continuum of outreach and access** which incorporates aggressive community-based outreach and HIV testing, comprehensive counseling, and immediate service linkage for persons who test positive for HIV. The system also utilizes **medical and non-medical case management services** that incorporate personalized care planning and ensure access to a full range of supportive services. Other Part A service categories making up the regional continuum of care include **mental health services, substance abuse treatment, oral health care, benefits counseling, emergency financial assistance, home health care, legal counseling, home health care,** and **hospice services.** Our system also incorporates extensive linkages with **HIV prevention services,** and includes **prevention with positives** programs integrated wherever possible throughout the spectrum of care.

B. SHARED VALUES AND GUIDING PRINCIPLES OF THE SAN FRANCISCO EMA

The core values that guide the San Francisco EMA reflect our continuing commitment to a comprehensive, high quality, client-centered, and culturally competent system of HIV care. However, our region's core values are continuing to shift in light of the realities of recent Part A funding cuts and continuing financial pressures on both the San Francisco EMA and the state of California as a whole. Shrinking resources coupled with expanding service populations means that our region must focus on HIV-infected populations who face the most severe needs, and for whom care is least accessible.

During the last comprehensive planning process in 2005, the San Francisco HIV Health Services Planning Council sponsored an exercise to identify a set of current core values which incorporate both our vision of an ideal system of HIV care and the growing need to ensure a streamlined, cost-effective system in which maximum service is provided with increasingly limited resources. This difficult task resulted in the prioritization of

seven core values which differed significantly from the core values identified the previous Comprehensive Plan produced in 2002. Both of these prioritized lists are presented in order of importance below as voted by the Planning Council:

2002 Core Values	2005 Core Values
Access	**Access**
Compassion & Respect	**Oversight / Accountability**
Excellence	**Efficiency**
Partnership	**Integration**
Integration	**Excellence**
Informed Choice	**Client Centered**
Equity	**Cultural Competency**

The core values originally identified during the 2005 planning process reflect a long-term trend in our EMA of moving away from simple portrayals of an ideal system of care to a more strategic and pragmatic approach designed to ensure that available dollars are spent to ensure access to high-quality services for those with the greatest level of need. **Because these core values continue to reflect the most critical guiding principles and ideals of the San Francisco EMA, the Planning Council made the decision to continue utilizing the core values identified in 2005 for the current 2009-2012 Comprehensive Plan.** Each of the San Francisco EMA core values is discussed briefly in the section below, along with a description of the **vision** for HIV services in the EMA which is linked to each core value.

Value: ACCESS

Vision: The leading core value of the San Francisco EMA remains **access to HIV care services.** Our care system is committed to the idea that the regional HIV care system must be accessible to **all** who need services, and that it must create **equal access** to services, eliminate **disparities** in care, and achieve **parity** in relation to the quality and accessibility of HIV service and support. Access means ensuring that clients are able to easily find a given service; to feel comfortable using that service; and to have full accessibility to service sites. Access means welcoming new clients while reaching out to those who are not in care in order to help them identify their HIV status and to bring them directly into the system in a welcoming and comfortable manner, including identifying and bringing into care hard to reach, underserved, and overlooked communities of PLWH. Access also means expanding system-wide linkages and integration in order to help clients move more easily from one service modality to another, and to access services in different parts of the San Francisco EMA. In an era of declining fiscal resources and expanding HIV-affected populations, ensuring HIV service access requires an increasingly delicate balance that often pits reduced resources

against the need to ensure that those with the greatest need continue to have full access to care.

Value: OVERSIGHT / ACCOUNTABILITY

Vision: A high priority is placed in our Plan on oversight and accountability. **This emphasis reflects our region's growing concern with ensuring the highest level of service quality within an environment of steadily declining fiscal resources.** The San Francisco EMA has always placed a high priority on **quality management**, **quality assurance**, and **continuous quality improvement** programs. However, these activities have assumed greater urgency as the EMA has become focused on ensuring that HIV-infected persons with the greatest need continue to have access to all essential services and treatments that can expand the quality and length of their lives. Oversight and accountability refers to fiscal oversight as well, and the need to ensure that dollars are being spent well, that they are serving the highest need populations in the most effective and efficient manner possible, and that Ryan White funds are continually used as the funding source of last resort. Oversight and accountability also means developing outcomes-based measures to ensure that HIV services are improving client health and life conditions, and are continually increasing the standards to which **all** members of the HIV service system are held in our region, including the three county governments that make up the San Francisco EMA, the region's HIV Health Services Planning Council, and the individual agencies who provide direct services to HIV-infected populations in our region.

Value: EFFICIENCY

Vision: The core value of efficiency reflects our growing awareness of the need to streamline and increase the cost-effectiveness of services in order to serve a growing HIV-infected population with declining dollars. All of the members of our regional HIV service system have made great strides over the past three years in increasing the efficiency of service planning and delivery, and these efforts are expected to increase dramatically over the three years encompassed by the present Plan. Over the past two years, for example, the Grantee has put in place a range of effective new systems to ensure that contracted agencies fully maximize all non-Part A funding streams available in the region. At the same time, the San Francisco HIV Health Services Planning Council has continually allocated a lower percentage of Part A funds to support direct Planning Council activities than most other EMAs in the US – a tradition that continues through the present day. These and similar steps will be take on increasing importance in order to ensure a "leaner, meaner" HIV service system that minimizes reductions in quality of care even as it copes with potential future funding reductions.

Value: INTEGRATION

Vision: Integration remains an important core value for the San Francisco EMA. Several years ago, the EMA prioritized integration and pioneered a new model of integrated service provision which allowed multiply diagnosed and severe need populations to access an intensive range of co-located services. This approach significantly increased the ability of complex and severe need populations to enter and remain in care, and helped us make significant inroads in reducing the unmet needs populations in our region. In our view, the vision of an integrated system is one in which all parts work together effectively, and in which there is clear communication between and among service agencies in order to increase collaboration and cooperation. In a fully integrated system, clients are able to move smoothly from one service to another based on their need for care, with services provided in a respectful, holistic, and culturally competent manner which ensures their long-term involvement with the system. Integration is particularly important in reaching people with HIV and AIDS who have multiple, complex, and severe needs, with a range of complementary services that include substance abuse treatment, mental health services, and housing. HIV and STD prevention efforts are also critical elements of effective, integrated systems of HIV care. Coordinating and integrating HIV services supports our system's overall goal of achieving positive health outcomes and long-term adherence to HIV medications for clients who wish to take them.

Value: EXCELLENCE

Vision: As the San Francisco EMA has expanded its understanding of how best to serve multiply diagnosed and severe need populations, our region's emphasis on the concept of **excellence** as an approach to HIV care – particularly as a means to involve and retain severe need populations in care – has expanded along with it. Today, as our EMA has embarked on a new era of HIV care with the implementation of seven **Centers of Excellence**, the ideal of an enhanced integrated system that can effectively serve severe need populations while improving the cost-efficiency of services is becoming a reality. As defined by our EMA, services defined as excellent: a) meet the highest professional standards of quality; b) are comprehensive, holistic, and responsive to client needs; c) are effective at improving health status and health outcomes; d) are provided by trained, competent, and sensitive staff; e) address social service needs as issues that affect health status; f) engage clients in the planning, delivery, and evaluation of services; and g) incorporate quality assurance and evaluation into program design. Maintaining excellent systems of care requires significant resources, however, even when such systems have achieved a high level of efficiency.

Value: CLIENT CENTERED

Vision: While the San Francisco EMA has always emphasized client centered services, the value is more strongly emphasized in the current Plan in order to stress the fact that in an environment of declining resources, meeting client needs must remain the **paramount** priority of the HIV system of care. In our view, client centered care refers to programs in which clients, consumers, and people living with HIV/AIDS are at the **center** of the system in a variety of roles, including as planners, providers, consumers, and evaluators. Client centered services are developed and managed specifically and exclusively to meet client needs, and to ensure that service responses facilitate care access and adherence at all levels. In our EMA, clients play a central role in assessing needs, identifying service gaps, prioritizing service categories, and developing, allocating funding, and supporting service programs such as our Centers of Excellence model. Because we have learned that a client centered perspective is the best way to plan, deliver, and evaluate HIV services, people living with HIV/AIDS are essential at every stage of these processes, including by serving as volunteers, staff, management, and Board members of AIDS service agencies, and as members of the San Francisco HIV Health Services Planning Council itself.

Value: CULTURAL COMPETENCY

Vision: Cultural competency refers to a service delivery approach which is tailored to meeting the full range of cultural needs and orientations that exists within a given client population. This means not only incorporating culturally competent approaches to racial and cultural issues such as ethnicity, language, national origin, and immigration status, but a wide range of additional factors that can define 'culture', including lifestyle, family structure, personal beliefs, and socioeconomic background. In a region as diverse as San Francisco, the issue takes on special meaning as both a challenge to service providers and an opportunity for our system of care to benefit and grow from our region's rich cultural traditions. Cultural competency is critical for ensuring that individuals feel comfortable, safe, respected, and welcomed in care, and is indispensable in ensuring that people with HIV/AIDS remain in care, and that they find supportive social networks. One researcher has written that cultural competence can be defined as "a set of congruent behaviors, attitudes and policies that come together as a system, agency, or among professionals, and that enable that system, agency, or group of professionals to work effectively in cross-cultural situations." Our EMA has continually worked to attain this goal by developing services and programs that are tailored to the needs of diverse ethnic populations including African Americans, Latinos, and Asians, and to members of specific sub-cultures such as transgender men and women, active substance users, and young people. This includes training providers in a range of specific cultural issues; working to ensure that services are delivered – wherever possible – by individuals who embody the cultural and linguistic characteristics

of the populations they serve; and by involving diverse cultural groups as representatives on the Planning Council.

SECTION 3: HOW WILL WE GET THERE: HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY AND ACCESSIBILITY OF PRIMARY MEDICAL SERVICES? A THREE-YEAR ACTION PLAN FOR THE SAN FRANCISCO EMA – MARCH 1, 2009 – FEBRUARY 28, 2012

Note: In the Action Plan below, each objective is followed by either a set of **Three-Year Action Steps** that cover the entire period of the Comprehensive Plan, and/or by a set of **Incremental Action Steps** that have specific annual deadlines and milestones. Three-Year Action Steps represent activities that are to be carried out **throughout** the three-year Plan period; therefore, they have no specific year-by-year deadlines. Incremental Action Steps are activities that will be implemented in several stages during the three-year Plan period, or that have specific completion deadlines prior to February 28, 2012.

PART I. LONG-TERM (THREE-YEAR) SYSTEMS, PLANNING, EVALUATION, & SERVICE GOALS

Goal # 1:	**To ensure a culturally competent EMA-wide continuum of essential services for all Ryan White-eligible persons with HIV/AIDS.**

Objective # 1.1.: Between March 1, 2009 and February 28, 2012, provide a continuum of high-quality, essential services to Ryan White-eligible persons with HIV/AIDS.

Three-Year Action Steps (3/1/09 – 2/28/12)

- In light of reduced funding resources, continue to prioritize Part A services to ensure access to essential care and to serve persons with the most critical needs and the least ability to access or pay for services.
- Continue to define a set of essential services based on identified client needs and emerging trends in the epidemic, including prioritizing HRSA primary medical services as part of the essential continuum of local HIV care.
- Continue to conduct outreach to HIV-infected individuals who are not in care, including participating in collaborative initiatives to test and link out-of-care populations to the service system.
- Continue to work toward a fully coordinated system of care that maximizes existing resources and expands collaboration and service integration.
- Respond to changes in Ryan White funding guidelines and requirements and overarching Ryan White legislation on an ongoing basis.
- Ensure integration and coordination of Ryan White funding and programs with potential health care reform initiatives as they develop.

Objective # 1.2.: Between March 1, 2009 and February 28, 2012, ensure that Part A-funded services are delivered in a culturally competent manner.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Continue to define and respect culture not only in terms of ethnicity and linguistic background, but in terms of the broadest possible definition of what constitutes cultural identity and community.
- Prioritize support for services that are provided in a culturally competent manner.
- Encourage and support the recruitment of staff and volunteers of Part A-funded agencies who are representative of the populations they serve.
- Encourage and facilitate the provision of cultural competency training within Part A-funded agencies in the San Francisco EMA.
- Continue to require that all Part A contracted agencies in the City of San Francisco submit an updated annual cultural competency plan as a condition of grant award.
- Continue to build upon outcomes and recommendations growing out of the 2008 San Francisco cultural humility program and DPH Health Equity principles.

Objective # 1.3.: Between March 1, 2009 and February 28, 2012, continue to prioritize Part A funding to support essential services and to provide care to severe needs populations in light of diminished resources.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Continue the EMA's tradition of comprehensively assessing needs and making difficult prioritization and allocation decisions to ensure access to services for severe need populations.
- Continue to consider scenarios for reduced funding as part of the EMA's annual prioritization and allocation process.
- Develop new systems and standards to address potentially reduced funding, including prioritizing services for severe need populations.
- In the event that services are reduced or eliminated as a result of reduced funding, or when clients are unable to access specific services due to service capacity reductions, ensure that individual client transition plans are in place to maximize access to needed resources and services to the extent available.

Goal # 2: To ensure a high-quality, integrated system of care for people with HIV/AIDS with severe needs.

Objective # 2.1.: Between March 1, 2009 and February 28, 2012, continue to implement and refine the EMA's Centers of Excellence as an advanced strategy for providing integrated care to severe need populations.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Monitor service delivery and client-level outcomes of the Centers of Excellence, and modify systems as needed to ensure adherence to quality improvement standards.
- Review and refine client eligibility criteria to respond to changes in the epidemic, changes in funding, and shifting demographic characteristics of the EMA and the local HIV epidemic.
- Review and implement recommendations growing out of the 2008 Centers of Excellence Analysis, including continuing to convene meetings of the Centers of Excellence providers working group.

Objective # 2.2.: Between March 1, 2009 and February 28, 2012, continue to improve and enhance data collection, analysis, and reporting in the San Francisco EMA to better identify the characteristics and needs of Ryan White clients and to pro-actively identify and respond to emerging client conditions and trends.

Three-Year Action Steps (3/1/09 – 2/28/12)

- By February 28, 2010, significantly enhance the quality and comprehensiveness of Ryan White HIV client level data by completing the transition from the Reggie data management system to ARIES – a system that will allow for direct linkage to electronic medical records systems used by local care provider agencies while facilitating expanded data coordination with the State Office of AIDS and counties throughout California.
- Achieve 95% data reporting compliance for all required data fields among Part A and B funded providers in the San Francisco EMA as a condition of grant award.
- Provide technical assistance to Part A agencies in data compliance requirements, including reviewing data management reports on a monthly basis and developing corrective action plans in collaboration with provider agencies to address and solve data reporting problems.
- Conduct ongoing analysis of client-level data to identify trends and characteristics among HIV populations and services; to track local service gaps and disparities; and to support prioritization and allocations deliberations by the San Francisco HIV Health Services Planning Council.

Goal # 3: To ensure a client-centered system of care that empowers people with HIV/AIDS at all levels.

Objective # 3.1.: Between March 1, 2009 and February 28, 2012, continue to ensure that people living with HIV/AIDS are central to the planning and allocation of services and resources in the San Francisco EMA.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Continue to ensure a high level of representation (at least 50%) by persons living with HIV/AIDS on the Planning Council as a whole, and, wherever possible, within all Planning Council committees.
- Expand outreach to persons living with HIV to encourage them to serve on the San Francisco HIV Health Services Planning Council, and expand education, training, mentoring, and support services to successfully retain these individuals.
- Utilize the client-centered needs assessment process as a strategy for obtaining the direct input of people living with HIV/AIDS in regard to local and regional service gaps and needs.
- Utilize town hall meetings as needed as a forum for soliciting input from consumers living with HIV/AIDS.
- Utilize annual client satisfaction surveys and grievance procedures at Part A-funded agencies to solicit client input and feedback regarding the quality of HIV care at the agency level.
- Provide opportunities for public comment at all Planning Council meetings, including meetings of Committees and Working Groups.

Objective # 3.2.: Between March 1, 2009 and February 28, 2012, conduct a comprehensive client needs assessment for the San Francisco EMA.

Incremental Action Steps		
Year One (3/1/09 – 2/28/10)	**Year Two (3/1/10 – 2/28/11)**	**Year Three (3/1/11 – 2/28/12)**
▪ Utilize findings of the previous year's needs assessment in the 2009 prioritization and allocation process.	▪ Begin planning and budgeting for a comprehensive client-centered needs assessment in 2011. ▪ Utilize findings of the previous year's needs assessment in the 2010 prioritization and allocation process.	▪ Conduct 1 comprehensive EMA-wide needs assessment and utilize findings in the 2011 prioritization and allocations process.

Objective # 3.3.: Between March 1, 2009 and February 28, 2012, conduct annual small-scale, focused needs assessments in 2009 and 2010 to more closely explore issues identified through the comprehensive needs assessment process.

Incremental Action Steps		
Year One (3/1/09 – 2/28/10)	**Year Two (3/1/10 – 2/28/11)**	**Year Three (3/1/11 – 2/28/12)**
▪ Beginning prior to the start of the fiscal year, identify the specific topic for the small-scale focused needs assessment to be conducted in 2009-2010. ▪ Develop a timeline and milestones for the 2009-2010 focused needs assessment, and begin implementation of project. ▪ Utilize provisional findings of the focused needs assessment project in the 2009 prioritization and allocation process.	▪ Beginning prior to the start of the fiscal year, identify the specific topic for the small-scale focused needs assessment to be conducted in 2010-2011. ▪ Develop a timeline and milestones for the 2010-2011 focused needs assessment, and begin implementation of project. ▪ Utilize provisional findings of the focused needs assessment project in the 2010 prioritization and allocation process.	▪ Utilize findings of the two prior focused needs assessments in addition to new information gathered through the 2011-2012 comprehensive needs assessment process, and begin to plan for the subsequent year's small-scale assessment project.

Goal # 4: To bring people with HIV who are not in care into care, including persons who know and do not yet know their HIV status.

Objective # 4.1.: Between March 1, 2009 and February 28, 2012, continue to implement strategies to identify the nature, scope, and needs of local out of care populations, incorporating this information into the annual prioritization and allocation process.

Three-Year Action Steps (3/1/09 – 2/28/12)
▪ Continue to conduct and refine the EMA's unmet need analysis on an annual basis, and comprehensively report the findings of this analysis to the HIV Health Services Planning Council. ▪ Work to expand the comprehensiveness of client information contained in the unmet needs analysis from all three EMA counties, and to potentially increase available information on the service needs and demographic characteristics of out-of-care populations. ▪ Continue to identify unmet needs through the comprehensive needs assessment process and through annual focused needs assessment projects, as well as through comprehensive consumer involvement in the EMA-wide planning process.

- Explore ways in which the comprehensive needs assessment process can better identify the characteristics and needs of out of care populations, and propose strategies for bringing these populations into care.

Objective # 4.2.: Between March 1, 2009 and February 28, 2012, implement strategies to better link HIV-positive individuals to care, including expanding linkages between HIV testing and care.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Utilize and refine the EMA's Centers of Excellence as a programmatic strategy for bringing people into care who are resistant or afraid to enter care, and for altering community norms to make HIV testing and treatment more acceptable.
- Ensure that HIV and non-HIV-specific 'first contact' points and agencies within the EMA continually refer and link HIV-positive clients to the local HIV care continuum.
- Continue to strengthen partnerships with the HIV prevention community and the local HIV Prevention Planning Council to ensure that persons who test positive for HIV are immediately and pro-actively linked to the HIV system of care.
- Continue to expand collaborations with the prenatal care system to encourage high-risk pregnant woman to seek prenatal care and to be effectively linked to HIV services in the event of a positive test result.
- Explore the service and funding implications of the EMA's growing population of 'late testers' – individuals who may suspect their HIV status but do not undergo testing or seek care until a later phase of their infection.

Objective # 4.3.: Between March 1, 2009 and February 28, 2012, continue to develop systems and partnerships that ensure that people who are in jail or prison or who have been recently incarcerated are fully linked to HIV care.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Conduct ongoing research and data analysis regarding incarcerated and recently incarcerated HIV infected and affected populations in the San Francisco EMA.
- Present information to the San Francisco HIV Health Services Planning Council on the current system of incarcerated care and outreach and the needs and characteristics of incarcerated and post-incarcerated populations as part of the annual prioritization and allocation process.
- Continue to assess the effectiveness of Centers of Excellence as a strategy for expanding the availability of effective, integrated, and culturally competent care for incarcerated and formerly incarcerated populations.
- Continue to support partnerships with agencies active in identifying and linking to care local jail and prison populations.

Goal # 5: Continue to improve the health status of people of color who are living with HIV/AIDS.

Objective # 5.1.: Between March 1, 2009 and February 28, 2012, continue to utilize local needs assessments and other data resources and studies to identify and address barriers to care and disparities in health outcomes for HIV-positive persons of color.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Continue to maintain and expand a specific focus to address health access and outcome disparities within communities of color in both the comprehensive needs assessment in 2011 and in small-scale, focused needs assessment projects conducted in 2009 and 2010.
- Continue to include information on the characteristics and needs of out-of-care populations of color in the annual unmet needs analysis presented to the Planning Council.
- Continue to include detailed service utilization and demographic data related to communities of color in the annual client data report presented by the Grantee to the Planning Council.
- Expand outreach, education, training, mentoring, and support services to successfully recruit and retain greater numbers of African Americans, Latinos, Asian/Pacific Islanders, and other persons of color on the San Francisco HIV Health Services Planning Council.

Objective # 5.2.: Between March 1, 2009 and February 28, 2012, continue to assess the effectiveness of Centers of Excellence as a strategy for expanding the availability of effective, integrated, and culturally competent care for members of HIV-infected communities of color.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Evaluate the effectiveness of Centers of Excellence in reaching and serving persons of color.
- Incorporate best practices related to cultural competency in communities of color within Planning Council decision-making and training activities.
- Work to incorporate a greater range of non-HIV-specific organizations that serve communities of color within the EMA's overall HIV service matrix.

Goal # 6: To improve the health status of women and transgender persons with HIV/AIDS.

Objective # 6.1.: Between March 1, 2009 and February 28, 2012, continue to utilize the results of the comprehensive needs assessment process and other data resources and studies to identify and address barriers to care and disparities in health outcomes for HIV-positive women and transgender persons, particularly persons of color.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Continue to maintain a focus on information related to the needs of women and transgender persons in both the comprehensive needs assessment to be conducted in 2011 and in small-scale, focused needs assessment projects conducted in 2009 and 2010.
- Continue to utilize the comprehensive client needs assessment process to explore the ways in which women and transgender persons access testing and care, and the barriers to care for those who are least likely to access services on their own.
- Continue to include information on the characteristics of women and transgender persons in the annual unmet needs analysis presented to the Planning Council.
- Continue to include detailed service utilization and demographic data related to women and transgender persons in the annual client data report presented by the Grantee to the Planning Council.
- Ensure an adequate and proportional representation by women and transgender persons - including persons living with HIV/AIDS - on both the Planning Council and its committees.
- Ensure the coordination of Ryan White Part D services for women and young people with the overall Part A-funded system of care.

Objective # 6.2.: Between March 1, 2009 and February 28, 2012, continue to assess the effectiveness of Centers of Excellence as a strategy for expanding the availability of effective, integrated, and culturally competent care for women.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Evaluate the effectiveness of Centers of Excellence in reaching and serving women.
- Incorporate best practices related to cultural competency in serving women within Planning Council decision-making and training activities.
- Work to incorporate a greater range of non-HIV-specific organizations that serve women within the EMA's overall HIV service matrix.

Goal # 7: To improve the health status of persons living with HIV/AIDS age 50 and above.

Objective # 7.1.: Between March 1, 2009 and February 28, 2012, continue to research and analyze the health and social service needs of persons age 50 and older living with HIV/AIDS, and utilize findings to enhance medical, service, and support systems that support their overall health and wellness.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Continue to maintain a focus on information related to the needs of 50 and older populations in both the comprehensive needs assessment to be conducted in 2011 and in small-scale, focused needs assessment projects conducted in 2009 and 2010.
- Continue to include information on the characteristics of persons 50 and older in the annual unmet needs analysis presented to the Planning Council.
- Continue to include detailed service utilization and demographic data related to persons 50 and older in the annual client data report presented by the Grantee to the Planning Council.
- Conduct special research to investigate and define the needs of persons 50 and older living with HIV/AIDS and to develop service approaches and interventions appropriate to their needs, including reviewing the existing literature and conducting specialized interviews with both clients and providers.
- Ensure an adequate and proportional representation by persons 50 and older living with HIV/AIDS on both the Planning Council and its committees.

Goal # 8: To prevent transmission of HIV and other STDs by HIV-positive individuals.

Objective # 8.1.: Between March 1, 2009 and February 28, 2012, continue to expand approaches for integrating prevention and care in relation to people with HIV/AIDS in the EMA

Three-Year Action Steps (3/1/09 – 2/28/12)

- Continue the activities of the San Francisco Points of Integration Joint Committee – a de facto committee of the HIV Prevention Planning Council and the HIV Health Services Planning Council.
- Continue to develop ways to integrate prevention and care in regard to people already living with HIV/AIDS.
- In 2009 and 2010, develop and disseminate prevention with positives best practices to expand the scope and quality of prevention with positives interventions in care settings.
- Continue to incorporate questions related to prevention with positives services and needs within the EMA's comprehensive needs assessment.

Goal # 9:	To coordinate HIV/AIDS care resources and maximize benefits access for persons with HIV/AIDS to ensure that Ryan White funds are used as the funding source of last resort.

Objective # 9.1.: Between March 1, 2009 and February 28, 2012, continue to ensure that persons with HIV in the San Francisco EMA are screened for benefits eligibility, have access to benefits assistance, and are referred to alternative providers as needed, while supporting advocacy activities to maintain and expand benefits for persons living with HIV/AIDS.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Through Part A funds, support client advocacy services that include benefits counseling and legal assistance to help persons with HIV maximize all resources to which they are entitled.
- Continue to support and promote benefits counseling education for medical and non-medical case managers and other relevant HIV client-level service staff throughout the EMA.
- Provide ongoing education to HIV providers and Ryan White contractors regarding appropriate benefits counseling, legal support, and other client advocacy referral services.
- Continue to provide Medicare Part D education and support in addition to other public and private benefits training and education for clients and agencies as needed.

Objective # 9.2.: Between March 1, 2009 and February 28, 2012, continue to ensure that Ryan White Part A funds are always used as the funding source of last resort.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Ensure that all Ryan White-funded agencies providing Medi-Cal-eligible services are certified to bill Medi-Cal.
- Ensure that all Ryan White-funded agencies are fully billing all applicable funding streams prior to utilizing Part A funds, including Medicare, Medicaid, and private insurance sources.
- Advocate for alternative resources to support Part A services, including primary care, housing, mental health, and substance abuse.

Objective # 9.3.: Between March 1, 2009 and February 28, 2012, continue to ensure that the San Francisco HIV Health Services Planning Council utilizes comprehensive information on all HIV-related Ryan White and non-Ryan White funding available in our region.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Investigate effective approaches in other EMAs for better understanding and utilizing information on non-Part A funding streams.
- Produce an annual listing of all local programs funded by both Ryan White and non-Ryan White public sources, including Parts B, C, D, E, & F; HOPWA; Medicare and Medicaid; the California AIDS Drug Assistance Program (ADAP); the Centers for Disease Control and Prevention (CDC); the Substance Abuse and Mental Health Services Administration (SAMHSA); the Veterans Administration (VA); and many others.
- Expand information provided in annual reports to the Planning Council on private HIV service funding received by local agencies and programs.

Goal # 10: To ensure the highest quality of HIV/AIDS services in all categories through implementation of a comprehensive Clinical Quality Management (CQM) Plan.

Objective # 10.1.: Between March 1, 2009 and February 28, 2012, continue to refine and implement the Grantee's Clinical Quality Management Plan, including expanding utilization of client data outcomes to monitor and enhance the quality of Ryan White-funded care.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Continue to track and refine the EMA's Clinical Quality Management Plan in collaboration with the San Francisco HIV Health Services Planning Council.
- Continue to monitor agency adherence to PHS guidelines and standards of care.
- Continue to track client-level quality service indicators for primary health services including ambulatory outpatient medical care, medical case management, mental health services, dental care, and outpatient substance abuse treatment services,.
- Explore potential expansions in the scope of client-level data reported by Ryan White-funded agencies.
- Convene quarterly EMA-wide quality management meetings involving QM specialists from the EMA's three counties to strategize new approaches for data sharing and coordination across our region.

Incremental Action Steps

Year One (3/1/09 – 2/28/10)	Year Two (3/1/10 – 2/28/11)	Year Three (3/1/11 – 2/28/12)
▪ Between March 1, 2009 and February 28, 2010, utilize implementation of the ARIES data management system and its direct interface with electronic medical records systems at Ryan	▪ Assess ARIES reporting capabilities on an indicator-by-indicator basis to identify potential enhancements in quality outcome reporting. ▪ Identify quality measures that can best serve as	▪ Refine client health and wellness benchmarks by applying them to special needs populations in the EMA, including transgender persons, persons of color, women, and recently incarcerated

White-funded agencies to increase the quality and accuracy of client-level data.
- Review health outcome data systems and develop improved approaches for EMA-wide data reporting and utilization.

indicators of overall client health, wellness, and self-sufficiency, including reviewing the literature on quality management indicators and standards, and integrating other models for assessing overall client wellness.
- Begin to establish benchmarks for client health and wellness using ARIES-reportable categories.

individuals .
- Finalize quality standards and benchmark indicators and develop processes for intervening and supporting agencies when benchmarks are not met.
- Formally implement outcome standards for client-level care by Ryan White-funded agencies in the San Francisco EMA.

Objective # 10.2.: Between March 1, 2009 and February 28, 2012, provide high-quality training, support, and technical assistance to Ryan White-funded agencies to improve and enhance the quality, impact, and effectiveness of HIV service provision and data reporting.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Develop and disseminate best practices guidelines for special populations, including previous best practices guidelines for transgender persons and Centers of Excellence, and upcoming best practices guidelines for prevention with positives.
- Continue to provide tailored trainings to increase the capacity and service quality of Ryan White agencies.
- Provide ongoing technical assistance to Ryan White agencies to increase skills and address specific service issues and needs, including supporting attainment of minimum data reporting standards mandated through Ryan White contracts.

Goal # 11: To ensure that the San Francisco HIV Health Services Planning Council conducts its activities efficiently and effectively and that it fulfills all mandated roles and responsibilities.

Objective # 11.1.: Between March 1, 2009 and February 28, 2012, continue to prioritize services and allocate funds through an efficient and well-informed prioritization and allocations process.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Conduct a comprehensive needs assessment process every three years.
- Utilize comprehensive service and resource data to annually inform the prioritization and allocation process, including epidemiological, unmet need, resource, and service

utilization data produced by the Grantee.
- Conduct a facilitated prioritization and allocation process every year.

Objective # 11.2.: Between March 1, 2009 and February 28, 2012, continue to fulfill all Planning Council requirements and expectations as defined by both HRSA and the local Planning Council itself.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Continue to ensure that Planning Council membership remains reflective of the local HIV epidemic and conforms to all mandated HRSA representation categories.
- On an annual basis, Planning Council leadership and staff complete all relevant Conditions of Award in a timely manner.
- Planning Council continually reviews the effectiveness of the administrative mechanism based on parameters agreed upon by both the Planning Council and the Grantee and provides a report to the Grantee on the findings of this review as needed.

Objective # 11.3.: Between March 1, 2009 and February 28, 2012, continually examine and revise the EMA's Comprehensive Three-Year HIV Services Plan, including tracking progress toward stated Plan objectives.

Three-Year Action Steps (3/1/09 – 2/28/12)

- Prior to the 2009-20010 fiscal year, establish standards and systems for monitoring and tracking progress toward Comprehensive Plan goals, objectives, and action steps, and for regularly reporting this progress to the Planning Council.
- Through the Council's Steering Committee, present recommendations to the Planning Council regarding strategies for moving objectives and action steps forward when needed.

PART II. SHORT-TERM (ONE-YEAR) CARE & TREATMENT GOALS

Note: Service estimates provided below reflect Part A service projections for the 2009-2010 Ryan White fiscal year based on current funding and service projections for the period March 1, 2008 - February 28, 2009. These numbers will be altered and revised based on Part A funds received and actual service funds allocated at the beginning of the 2009-2010 Ryan White fiscal year.

Goal # 12: To provide a high-quality continuum of essential care and services for all Ryan White-eligible persons with HIV/AIDS.

Objective # 12.1: Between March 1, 2009 and February 28, 2010, ensure that Part A funds are allocated to provide access to HRSA-defined core medical services for Ryan White-eligible persons who need them, including severe need and special populations and other groups.

One-Year Action Steps (3/1/09 – 2/28/10)

- Provide an estimated total of **65,467** units of **Outpatient / Ambulatory Health Services** - including Centers of Excellence services - to a total of **5,016** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **6,706** units of **Oral Health Care Services** to a total of **1,211** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **2,965** units of **Home Health Care Services** to a total of **81** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **4,465** units of **Home and Community-Based Health Services** to a total of **88** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **9,828** units of **Hospice Services** to a total of **358** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **17,803** units of **Mental Health Services** to a total of **1,190** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **15,184** units of **Medical Case Management Services** to a total of **900** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **63** units of **AIDS Pharmaceutical Assistance Services** to a total of **31** unduplicated Ryan White-eligible HIV-infected individuals in Marin County only.
- Provide an estimated total of **1,060** units of **Outpatient Substance Abuse Services** to a total of **3** unduplicated Ryan White-eligible HIV-infected individuals in Marin County only (outpatient substance abuse services in San Francisco County are provided directly through Centers of Excellence, while in San Mateo County, outpatient substance abuse services are combined with residential substance abuse services).

Objective # 12.2: Between March 1, 2009 and February 28, 2010, ensure that Part A funds are allocated to provide access to HRSA-defined support services for Ryan

White-eligible persons who need them, including severe need and special populations and other groups.

One-Year Action Steps (3/1/09 – 2/28/10)

- Provide an estimated total of **47,818** units of **Non-Medical Case Management Services** - including Benefits Counseling and Money Management Services - to a total of **1.009** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **1,831** units of **Emergency Financial Assistance Services** to a total of **921** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **450,192** units of **Food Bank / Home-Delivered Meal Services** to a total of **740** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **2,072** units of **Housing Services** - including Residential Mental Health Services - to a total of **196** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **597** units of **Legal Services** to a total of **123** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **4,301** units of **Residential Substance Abuse Services** to a total of **79** unduplicated Ryan White-eligible HIV-infected individuals.
- Provide an estimated total of **500** units of **Medical Transportation Services** to a total of **50** unduplicated Ryan White-eligible HIV-infected individuals in Marin County only.
- Provide an estimated total of **28** units of **Psychosocial Support Services** to a total of **28** unduplicated Ryan White-eligible HIV-infected individuals in San Mateo County only.

SECTION 4:
HOW WILL WE MONITOR OUR PROGRESS: HOW WILL WE EVALUATE OUR PROGRESS IN MEETING OUR SHORT AND LONG-TERM GOALS?

Monitoring and evaluation of the new Comprehensive Plan will be the joint responsibility of the San Francisco EMA HIV Health Services Planning Council and the Part A Grantee agency, the San Francisco Department of Public Health HIV Health Services, the latter working in collaboration with the HIV/AIDS programs in both Marin and San Mateo Counties. Joint Plan monitoring is essential because the Plan's action steps involve several different entities within the local HIV services system, often working in conjunction with one another to enhance and improve the continuum of care.

At the Planning Council level, ongoing monitoring of the Plan will be the responsibility of the Council's **Steering Committee**. The first stage in the Plan monitoring process will involve the Committee's preparation of a **Plan Implementation Grid** in collaboration with representatives of HIV Health Services and representatives of other Council committees. The Implementation Grid will list all action steps contained in the Plan in chronological order by start dates, milestones, and deadlines, along with specific assignments detailing the entities responsible for carrying out each activity. The Implementation Grid will be continually monitored by the Steering Committee, and Plan monitoring will become a regular part of the Committee's meeting agendas. The Steering Committee will regularly report to the Planning Council on progress achieved toward Plan action steps as part the Committee's regular reports at Council meetings on the fourth Monday of each month. Where needed, the Steering Committee will highlight key issues or problems in Plan implementation, and will hold discussions with the Council where needed to address specific barriers or problems in executing specific action steps. The Steering Committee will also present updated versions of the Plan Implementation Grid for Council review as needed which chart progress toward the start dates, milestones, and completion deadlines listed in the Plan.

It is important to note that the Plan Implementation Grid will include not only specific completion deadlines for all relevant action steps, but will also include projected times for work to **begin** on specific programs, accompanied by **interim deadlines** to ensure that action items are proceeding in a timely fashion. In this way, the Steering Committee can spot delays in Plan implementation before stated deadlines, while giving ample time for responsible parties to begin their work on action steps in advance of projected completion dates.

Because the Comprehensive Plan is designed to be a living document that will be continually reviewed, updated, and adapted to respond to changes in the epidemic and changes in the HIV funding environment, all Planning Council committees and the Grantee will have the opportunity to suggest modifications or additions to the Plan throughout the

Plan period. For example, if a specific Council committee wishes to add a new objective or a new set of action steps to the Plan in order to address an identified need related to an emerging population, the committee will have the opportunity to bring this recommendation forward to the Planning Council as a whole during one the Council's regular monthly meetings, and to submit the proposed change directly to the Grantee agency. The Council will have the opportunity to discuss and vote on the amendment to the Plan, including recommending changes or additions to the new objective or action steps. At the same time, the Grantee will also have the opportunity to review and revise the new objective or action step, and to discuss feedback with the Planning Council. If approved, the changes will be added to the Plan Implementation Grid, and tracking of those new activities will become the responsibility of the Steering Committee.

Progress toward objectives and action steps contained in the Comprehensive Plan will be reported to the US Health Resources and Services Administration through appropriate reports submitted by the Grantee agency, and through information contained in the EMA's annual Part A grant application. The annual assessment of the administrative mechanism conducted by the HIV Health Services Planning Council also may include information on progress toward Plan objectives and action steps that are either the responsibility of the Grantee agency or that involve collaborative activities involving both the Grantee and the Planning Council.

ENDNOTES

[1] US Census Bureau, *California QuickFacts*, Marin, San Francisco, and San Mateo Counties, Revised August 31, 2007, http://quickfacts.census.gov
[2] Ibid.
[3] San Francisco Unified School District, *Preliminary Results from the 2001 High School Youth Risk Behavior Survey*, San Francisco: SFUSD, 2002.
[4] US Census Bureau, Population Division, *Cumulative Estimates of the Components of Population Change for Counties in California: April 1, 2000 to July 1, 2003*, Washington, DC, April 9, 2004, www.census.gov
[5] State of California Department of Health Services, Office of AIDS, *California AIDS Surveillance Report: Cumulative Cases as of July 31, 2008*, Sacramento, CA, 2008, http://www.cdph.ca.gov/data/statistics/Documents/OA-2008-07HIVAIDSMerged.pdf
[6] Ibid.
[7] These and subsequent AIDS and HIV statistics in this section were derived from epidemiological data reports received from the Marin, San Francisco, and San Mateo County health departments in August 2008. The numbers of PLWHA in the three counties are based on an assumption of a 1-to-1.1 ratio of PLWA to PLWHA, based on consensus estimates obtained in the City of San Francisco between June 2005 and April 2006, including a review of over 50 different sources of data, and solicitation of the opinions of approximately 75 HIV/AIDS researchers, service providers, public health officials, and epidemiologists. This method is used to account for those infected but not in care or unaware of their infection (therefore not recorded in the HIV reporting system).
[8] US Centers for Disease Control and Prevention, "Cases of HIV Infection and AIDS in the United States and Dependent Areas, 2006, *HIV/AIDS Surveillance Report*, Vol. 18, April 2008, http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2006report/default.htm.
[9] San Francisco Department of Public Health, HIV Epidemiology Section, *HIV/AIDS Epidemiology Annual Report 2007*, San Francisco, CA, May 2008, sfhiv.org/files/data_reports/hiv_aids_annual_rpt/HIVAIDSAnnlRpt2007.pdf
[10] Ibid.
[11] US Centers for Disease Control and Prevention, Op. Cit.
[12] Per capita PLWA rates for Los Angeles County, New York City, and the City and County of San Francisco derived by comparing reported people living with AIDS as of December 31, 2007 in the case of Los Angeles and San Francisco and June 30, 2007 in the case of New York City with US Census Bureau estimated recent populations for all three regions. LA County: 22,455 PLWA as of 12/31/07 / 2006 estimated Census Population: 9,948,081; New York City: 62,348 PLWA as of 6/30/07 / 2003 estimated Census Population: 8,085,742; San Francisco: 9,820 PLWA as of 12/31/07 / 2006 Census Population: 744,041. Sources of AIDS data: County of Los Angeles Department of Health Services, Public Health, *HIV/AIDS Semi-Annual Surveillance Summary, Cases Reported as of December 31, 2007*, Los Angeles, CA, January 2008, lapublichealth.org/wwwfiles/ph/hae/hiv/HIVAIDS%20semiannual%20surveillance%20summary_January2008.pdf and The New York City Department of Health and Mental Hygiene, *HIV Epidemiology & Field Services Semiannual Report*, Vol. 3, No. 1, New York, NY, April 2008, www.nyc.gov/html/doh/downloads/pdf/dires/dires-2007-report-semi1.pdf
[13] The New York City Department of Health and Mental Hygiene, *HIV Epidemiology & Field Services Semiannual Report*, Vol. 3, No. 1, New York, NY, April 2008, www.nyc.gov/html/doh/downloads/pdf/dires/dires-2007-report-semi1.pdf
[14] Because transgender identity is not tracked in San Mateo County HIV surveillance data, the actual EMA-wide total of transgender PLWHA is believed to be much higher than these estimates.
[15] Please note that statistics given in this section are for individuals' **current age** as of December 31, 2007, rather than age at diagnosis.
[16] These and subsequent HIV/AIDS statistics in this section derived from epidemiological data reports received from the Marin County, San Francisco County, and San Mateo County health departments in September 2007.
[17] All cost estimates in the Emerging Populations section based on actual average cost per person of $14,605.81, adjusted based on complexity of care for each population. In the case of PLWHA 50 years of age and over, for example, the cost estimate is based on a per person cost of $20,000 for 8,082 total PLWHA age 50 and above with an estimated 80% in care rate (n=6,466).

[18] E.g., Herbst, et al., Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systemic review, *AIDS and Behavior*, 12(1):1-17, 2007.
[19] Clements, K., et al., HIV prevention and health service needs of the transgender community in San Francisco, *International Journal of Transgenderism*, 3(1+2), 1999.
[20] Clements-Nolle, K., HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention, *American Journal of Public Health*, 91(6):915-921, 2001.
[21] Bockting, W., Robinson, B., & Rosser, B., Transgender HIV prevention: A qualitative needs assessment, *AIDS Care*, 10(4):505-25, August 2998.
[22] Based on at least 500 total HIV-infected transgender persons of color x .75 in care rate (n=375) x estimated $15,000 cost per person.
[23] Based on 7,483 total MSM of color x .75 in care rate (n=5,612) x estimated $15,000 cost per person.
[24] Based on 1,666 total homeless PLWHA x .60 in care rate (n=1,000) x estimated $20,000 cost per person.
[25] Based on 3,568 total African American PLWHA x .68 in care rate (n=2,426) x estimated $18,000 cost per person.
[26] Based on 3,638 total Latino/a PLWHA x .70 in care rate (n=2,547) x estimated $18,000 cost per person.
[27] Dilley, D. & Loeb, L., *The Future of Publicly Funded HIV/AIDS Mental Health Services in San Francisco: Lessons from the First Two Decades*, Findings from a study funded by the California Endowment, San Francisco, CA, August 15, 2002.
[28] San Francisco Department of Public Health, HIV/AIDS Epidemiology Section, Op. Cit.
[29] Source: Data from Reggie, San Francisco County's client database system
[30] Ibid.
[31] San Francisco Department of Public Health, HIV/AIDS Epidemiology Section, Op. Cit.
[32] Source: 2003 Comprehensive San Francisco EMA HIV Needs Assessment
[33] Ibid.
[34] Based on 2000 US Census data related to ethnic minority populations, applied to Latino and Asian/Pacific Islander HIV-infected populations.
[35] Based on total MSM PLWA/PLWHA populations in San Francisco EMA as of December 31, 2007 as a percentage of the total estimated self-identified gay/bisexual male population at approximately 5% of the EMA's total male population.
[36] Clements, K., Wilkinson, W., Kitano, K. & Marx, R., "HIV prevention and health services needs of the transgender community in San Francisco," *International Journal of Transgenderism*, 3(1), 1999.
[37] Source: 2003 Comprehensive San Francisco EMA HIV Needs Assessment
[38] State of California Department of Health Services, STD Control Branch, "Primary and Secondary Syphilis, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2003-2007 Provisional Data," Sacramento, CA, July 15, 2008.
[39] Ibid.
[40] Sources: Ibid. above for California data; for national data, US Centers for Disease Control and Prevention, *Trends in Reportable Sexually Transmitted Diseases in the United States, 2005: National Surveillance Data for Chlamydia, Gonorrhea, and Syphilis*, Atlanta, GA, December 2006.
[41] State of California Department of Health Services, STD Control Branch, "Primary and Secondary Syphilis, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2003-2007 Provisional Data," Op. Cit.
[42] State of California Department of Health Services, STD Control Branch, "Gonorrhea, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2003-2007 Provisional Data," Sacramento, CA, July 15, 2008.
[43] Sources: Ibid. above for California data; for national data, US Centers for Disease Control and Prevention, *Cases of sexually transmitted diseases reported by state health departments and rates per 100,000 civilian population: United states, 1941-2004*, Atlanta, GA, 2006, http://www.cdc.gov/std/stats/tables/table1.htm
[44] Ibid.
[45] State of California Department of Health Services, STD Control Branch, "Gonorrhea, Cases & Rates for Females Ages 15-24, California Counties & Selected City Health Jurisdictions, 2003-2007 Provisional Data," Sacramento, CA, July 15, 2008.
[46] State of California Department of Health Services, STD Control Branch, "Chlamydia, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2003-2007 Provisional Data," Sacramento, CA, July 15, 2008.
[47] Ibid.

[48] Sources: Ibid. above for California data; for national data, US Centers for Disease Control and Prevention, *Chlamydia - Reported cases and rates by state, ranked by rates: Untied States, 2004*, Atlanta, GA, 2006, http://www.cdc.gov/std/stats/tables/table2.htm

[49] Chesson, H., Blandford, J., Gift, T., Tao, G., & Irwin, K., "The estimated direct medical cost of sexually transmitted diseases among American youth, 2000," *Perspectives in Sexual Reproductive Health*, Vol. 36, No. 1, January-February 2004.

[50] De Lissovoy, G., Zenilman, J., Nelson, K., Ahmed, F., & Celentano, D., "The cost of a preventable disease: Estimated US national medical expenditures for congenital syphilis, 1990," *Public Health Reports*, Vol. 110, No. 4, July – August 1995.

[51] Chesson, H., Pinkerton, S., Viogt, R., & Counts, G., "HIV infections and associated costs attributable to syphilis coinfection among African Americans," *American Journal of Public Health*, Vol. 93, No. 6, June 2003.

[52] Calculations based on the following: a) For total STI costs, calculation based on average of $2,000 per capita for syphilis and gonorrhea treatment (228 and 2,348 new cases, respectively, in 2007) and $1,000 average per capita for Chlamydia treatment (6,242 new cases in 2007) in the first year following diagnosis; b) For STI treatment costs among people with HIV, calculation based on estimated 5% of persons living with HIV or AIDS becoming infected with non-HIV STI annually (n=1,190) at average treatment cost of $2,500 per capita; and c) New HIV cases facilitated to other STIs based on a total of 30 new HIV infections per year at an annual treatment cost of $25,000 x 10 years per person.

[53] St. Lawrene, J. & Brasfield, T., "HIV high risk behavior among homeless adults," *AIDS Education Prevention*, 7(1):22-31, 1995.

[54] National Low Income Housing Coalition, *Out of Reach 2005,*, Washington, DC, http://www.nlihc.org/oor2005/

[55] Ibid.

[56] US Department of Housing and Urban Development, *Appendix B: Explanation of Fair Market Rent*, Excerpt from Notice of Final Fair Market Rents (FMRs) for Fiscal Year 2006, www.huduser.org/datasets/fmr/fmr2006f/FY2006FMR_Premable.pdf

[57] National Low Income Housing Coalition, *Local Area Low Income Housing Database*, compiled from 2000 US Census Data, Washington, DC, 2003, www.nlihc.org/research/lalihd/

[58] City and County of San Francisco, Office of the Mayor, *Number of Homeless on San Francisco's Streets Declines 41%*, Press Release, February 14, 2006.

[59] San Francisco Ten Year Planning Council, *The San Francisco Plan to Abolish Chronic Homelessness*, San Francisco, CA, September 2004.

[60] Fagan, K., "S.F.'s homeless aging on the street," *San Francisco Chronicle*, Friday, August 4, 2006.

[61] Zolopa, A., et al., "HIV and tuberculosis infection in San Francisco's homeless adults: Prevalence and risk factors in a representative sample," *Journal of the American Medical Association*, 272(6), 1994.

[62] San Francisco Department of Public Health AIDS Office, "Data from the TREAT Study," in *2001 HIV Consensus Meeting Report, San Francisco*, San Francisco, CA, June 4, 2001.

[63] Charebois, E., et al., "HIV seroprevalence among homeless and marginally housed adults in San Francisco," Presented at the San Francisco HIV Consensus Meeting, Emeryville, CA, May 15-16, 2001.

[64] San Francisco Department of Public Health, *1998 Annual AIDS Surveillance Report*, San Francisco, CA, 1999, www.dph.sf.ca.us/PHP/RptsHIVAIDS/survpt.pdf

[65] San Francisco Department of Public Health, HIV/AIDS Epidemiology Section, Op. Cit.

[66] The Lewin Group, *Cost of Serving Homeless Individuals in Nine Cities: Chart Book*, Prepared for The Partnership to End Long-Term Homelessness, November 19, 2004.

[67] San Francisco Department of Public Health, Housing and Urban Health, *Evaluation of Direct Access to Housing Health Care Utilization and Housing Retention*, San Francisco, CA, August 2005.

[68] Diamond, P. & Schneed,, S., *Lives in the Shadows: Some of the Costs and Consequences of a "Non-System" of Care*, Hogg Foundation for Mental Health, University of Texas, Austin, TX, 1991.

[69] Calculation based on total 23,794 persons with HIV living in the EMA with a conservative annual homelessness rate of 7% (n=1,666) and a minimum annual cost of $10,000 to meet these individuals' homeless-related needs.

[70] Percentage based on aggregated estimated uninsured rates for San Francisco, San Mateo, and Marin Counties provided in University of California, Los Angeles Center for Health Policy Research, *The State of Health Insurance in California: Findings from the 2005 California Health Interview Survey*, Los Angeles, CA, July 2007, www.healthpolicy.ucla.edu/pubs/files/SHIC_RT_072807.pdf

[71] Ibid.
[72] Estimate based on 2008 HHS Poverty Guidelines of $17,600 for 3-person household x 300% = $52,800 per year, and 2000 Census total of 296,639 households in Marin, San Francisco, and San Mateo Counties earning $49,999 per year or less x avg. 3 members per household = at least 808,917 total persons living at 300% of FPL or below.
[73] Estimate of total PLWHA living at 300% of poverty or below based on 100% rate of PLWH/A in the Ryan White system living at or below 300% of poverty (n=6,571) plus conservatively estimated 47.7% rate of 300% at or below FPL for all other PLWA/H (same as overall EMA-wide rate) (17,223 PLWHA not in the Ryan White system x .477 = 8,215).
[74] Calculation based on current annual projected EMA-wide HIV expenditures of $173,961,269 (see Table in Attachment 4) x .621, representing estimated percentage of all persons with HIV/AIDS living in poverty.
[75] California Criminal Justice Statistics Center, *Statistics: Supervision, 1994-2005 – Adult Probation and Local Adult Supervision,* Sacramento, CA, 2006, http://ag.ca.gov/cjsc/statisticsdatatabs/SuperCo.php
[76] California Criminal Justice Statistics Center, *Statistics: Felony and Misdemeanor Arrests, 1994-2005,* Sacramento, CA, 2006, http://ag.ca.gov/cjsc/statisticsdatatabs/ArrestCoFel.php
[77] Kittkraisak., W., et al, "Incarceration among young injectors in San Francisco: Associations with risk for hepatitis C infection," *Journal of Substance Use,* 11(4):271-278, August 2006.
[78] Calculation based on 10% of HIV cases among incarcerated persons with HIV in San Francisco having been infected through unsafe drug and sex behaviors while incarcerated (n=8) at an average $12,000 per person per year for medical treatment and support services, along with an additional estimated $2,000 per year in costs for the 76% of formerly incarcerated persons with HIV whose infection is IDU-related (n=638).
[79] Clark, C., "The results behind NARCONON's truth about drugs program," *San Francisco Chronicle,* San Francisco, CA, June 23, 2004.
[80] Liewinko, M., Op. Cit.
[81] The San Francisco Injury Center, San Francisco Department of Public Health, *Profile of Injury in San Francisco 2004,* San Francisco, CA, 2002, December 2004, www.surgery.ucsf.edu/sfic/profile05.pdf#search=%22Profile%20of%20Injury%20in%20San%20Francisco%22
[82] Heredia, C., "Dance of death, first of three parts: Crystal meth fuels HIV," *San Francisco Chronicle*, San Francisco, CA, May 4, 2003.
[83] Bajko, M., "Campaigns focuses on dark side of speed use," *Bay Area Reporter,* San Francisco, October 21, 2004.
[84] San Francisco Department of Public Health HIV Prevention Section, *The Party and Play Study: HIV Risk in a Late-Night Population of MSM: Descriptive Results*, San Francisco, CA, February 4, 2003.
[85] Executive Office of the President, Office of National Drug Control Policy, *The Economic Costs of Drug Abuse in the United States: 1992-1998,* Washington, DC, September, 2001, , www.whitehousedrugpolicy.gov/publications/pdf/economic_costs98.pdf
[86] National Institute on Drug Abuse, *NIDA InfoFacts: Drug Addiction Treatment Methods,* Rockville, MD, November 5, 1999, www.nida.nih.gov/Infofacts/TreatMeth.html
[87] Sources: Ibid. & Memorandum from James Stillwell, San Francisco County Department of Public Health, September 9, 2005.
[88] Sources: San Francisco Department of Public Health Community Health Epidemiology and Disease Control Section and US Centers for Disease Control and Prevention, National Center for Infectious Disease, Viral Hepatitis Surveillance, *Disease Burden from Hepatitis A, B, and C in the United States,* Atlanta, GA, October 1, 2004, www.cdc.gov/ncidod/diseases/hepatitis/resource/dz_burden02.htm
[89] Source: San Mateo County Health Department, *Hepatitis C in San Mateo County*, Redwood City, CA, 2005, http://www.smhealth.org/smc/department/home/0,,1954_1560623_195429,00.html
[90] Source: Marin County Health Department - report specifically prepared for this application, September 2004.
[91] Wong, J, "Pharmacoeconomics of Combination Therapy for HCV," Brief submitted at the Update on Liver Disease & Hepatitis Conference, February 2000.
[92] Harvard School of Public Health, "As Testing Campaigns Identify More People with Asymptomatic Hepatitis C Infection, Benefits, Risks, and Cost-Effectiveness of Early Treatment Uncertain," Press Release, Cambridge, MA, July 8, 2003.
[93] Wong, J., McQuillan, G., McHutchison, J., & Poynard, T., "Estimating future hepatitis C morbidity, morality, and costs in the United States," *American Journal of Public Health,* Vol. 90, No. 10, October 2000.

[94] Source: California Health and Human Services Agency, *Report on Tuberculosis in California*, 2007, Sacramento, CA, August 2008, www.cdph.ca.gov/data/statistics/Documents/TB_Report_2007.pdf
[95] Sources: Ibid. & US Centers for Disease Control and Prevention, Division of Tuberculosis Elimination, "Reported Tuberculosis in the United States, 2004," *Surveillance Reports*, Atlanta, GA, September 2005, http://www.cdc.gov/nchstp/tb/surv/surv2004/default.htm
[96] Rajbhandary, S., Marks, S., & Bock, N., "Costs of patients hospitalized for multidrug-resistant tuberculosis," *International Journal of Tubercular Lung Disease*, Vol. 8, No. 8, August 2004.
[97] Source: San Francisco Department of Public Health, Behavioral Health, estimates prepared for FY 2003 San Francisco EMA Ryan White Part A application.
[98] Soltau, A., "Bad economy may up suicide risk," *San Francisco Examiner*, San Francisco, CA, June 19, 2003
[99] The San Francisco Injury Center, Op. Cit.
[100] Dilley, D. & Loeb, L., Op. Cit.
[101] Mayne, T., et al., "Depressive affect and survival among gay and bisexual men infected with HIV," *Archives of Internal Medicine*, 156(19), October 1996.
[102] Sources: City and County of San Francisco, Office of the Mayor, *Number of Homeless on San Francisco's Streets Declines 41%*, Press Release, February 14, 2006; San Francisco Ten Year Planning Council, *The San Francisco Plan to Abolish Chronic Homelessness*, San Francisco, CA, September 2004; Community Inter-Action Partnership, A Project of the Marin Continuum of Housing and Services *The Annual Update to A Clear and Present Crisis*: *A Profile of New Cases of Homelessness and Near-Homelessness in Marin County in 2001 and 2002*, San Rafael, CA, 2003; County of San Mateo Human Services Agency, *Housing our People Effectively (HOPE): Ending Homelessness in San Mateo County, 10-Year Plan to End Homelessness*, San Mateo, CA, March 2006.
[103] Calculation based on total 23,794 persons with HIV living in the EMA as of December 31, 2007 with a conservative annual homelessness rate of 7% (n=1,665).
[104] California Criminal Justice Statistics Center, *Statistics: Supervision, 1994-2005 – Adult Probation and Local Adult Supervision*, Sacramento, CA, 2006, http://ag.ca.gov/cjsc/statisticsdatatabs/SuperCo.php
[105] California Criminal Justice Statistics Center, *Statistics: Felony and Misdemeanor Arrests, 1994-2005*, Sacramento, CA, 2006, http://ag.ca.gov/cjsc/statisticsdatatabs/ArrestCoFel.php
[106] Harder+Company Community Research, *HIV in San Francisco: Estimated Size of Populations at Risk, HIV Prevalence, and HIV Incidence for 2006*, Developed by Willi McFarland, San Francisco Department of Public Health, in partnership with the San Francisco HIV Prevention Planning Council, San Francisco, CA, April 2007, http://sfhiv.org/files/full_council/2007/04-12/Epi%20Update%20FINAL.doc
[107] These and other Centers of Excellence statistics drawn from Zellers, R. & Whitney, E., *Final Public Report for Centers of Excellence Analysis*, Prepared for HIV Health Services, San Francisco Department of Health, San Francisco, CA, September 2008.
[108] Harder+Company Community Research, *Highlights from the 2008 San Francisco EMA HIV Health Services Needs Assessment*, prepared for the San Francisco HIV Health Services Planning Council, San Francisco, CA, August 2008.
[109] US Centers for Disease Control and Prevention, *Advancing HIV Prevention Progress Summary, April 2003 - September 2005*, Rockville, MD, September 2005, http://www.cdc.gov/hiv/prev_prog/AHP/resources/factsheets/Progress_2005.pdf
[110] Zellers, R. & Whitney, E., *Final Public Report for CoE Analysis*, Prepared for HIV Health Services, San Francisco Department of Public Health, San Francisco, CA, September 2008.