SAN FRANCISCO, CALIFORNIA

ELIGIBLE METROPOLITAN AREA

FISCAL YEAR 2007

APPLICATION FOR GRANT FUNDS UNDER

TITLE I

RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY ACT

Submitted to:
THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
HIV/AIDS Bureau
Division of Service Systems

Under Title XXVI, Public Law 101-381
Public Health Service Act
As amended by Public Laws 104-146 and 106-345,
Ryan White CARE Act Amendments of 1996 and 2000
CFDA 93.914

Submitted by the
HIV Health Services Section
AIDS Office
San Francisco Department of Public Health
San Francisco, CA

September 27, 2006

unedited

City and County of San Francisco **Department of Public Health**

September 28, 2006

HRSA Grants Application Center
Legin Group, Inc.
910 Clopper Road, Suite 155 South
Gaithersburg, MD 20878

RE: HIV Emergency Relief Grant Program Title I
Program Announcement Number: HRSA-07-059
CFDA Number: 93.914
Grants.gov Tracking Number: GRANT00149497

The San Francisco Department of Public Health, AIDS Office, HIV Health Services Section has submitted our competing continuation application electronically through Grants.gov for the "Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Title I Grant" for FY 2007. As per the program announcement instructions, we have enclosed the signed face page on form SF424.

If you have any questions, please contact Michelle Long, Director of HIV Health Services at (415) 554-9043 for programmatic issues and Suzanne Wang, Senior Administrative Analyst at (415) 255-3512 for administrative and fiscal issues.

Sincerely,

James Loyce, Jr.
Deputy Director of Health
Director of AIDS Programs

PROJECT ABSTRACT

Located along the western edge of the San Francisco Bay in Northern California, the San Francisco EMA is a unique and diverse region encompassing three counties - Marin in the north, San Francisco in the center, and San Mateo in the south. 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 **46.7** square miles, making it by far the smallest county in California geographically, and the sixth smallest county in the US in terms of land area. The 2003 population of the EMA was estimated by the US Census Bureau at **1,695,211**, including **246,073** in Marin County, **751,682** in San Francisco County, and **697,456** in San Mateo County. However, while the population density of Marin County is **473** persons per square mile, the density of San Francisco County is **15,993** persons per square mile - the highest population densities of any county in the U.S with the exception of New York. Just under **50%** of the EMA's residents are persons of color, including large Asian/Pacific Islander (**23.3%**), Latino (**16.9%**), and African American (**5.3%**) populations. A large number of Asian and Latino immigrants also reside in the EMA, and over **40%** of EMA residents speak a language other than English at home.

As of December 31, 2005, a cumulative total of **30,196** cumulative AIDS cases had been diagnosed in the EMA, with over **20,000** persons having died of AIDS. Combined data for the EMA's three counties indicate that **10,941** persons were living with AIDS as of December 31, 2005, while another **11,698** individuals were living with HIV, for a total of **22,639** persons living with HIV infection in the three-county region. This means that nearly **1 in every 75 residents of the San Francisco EMA is currently infected and living with HIV.** 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, San Francisco continues to have the **highest per capita prevalence of cumulative AIDS cases** and the **third highest number of total AIDS cases** of any city in the United States, and AIDS remains the second leading cause of premature death in the city.

Throughout our EMA, the emphasis on **high-quality, client-centered primary medical care services** is at the heart of the continuum of care, with case management services providing individualized coordination and entry points to the full range of social and supportive services. In addition to 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, just north of San Francisco, 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 out between them. In November 2005, our EMA launched the **Centers of Excellence program** – an innovative network of HIV service providers specifically designed to involve and retain complex, hard-to-reach, and multiply diagnosed populations in care. The **seven** new Centers of Excellence - **five** supported through Title I funding - form a cost-effective system in which the care needs of severe need and special populations can be addressed within the context of **one-stop community-based centers** in which **multidisciplinary teams** provide extremely high levels of HIV specialist medical care, integrated with a variety of additional on-site services designed to stabilize individuals and maintain them in treatment. The Centers have already begun to attract national attention as a model for expanding access to the HIV continuum of care for severe need populations experiencing growing rates of HIV infection.

ADVANCING A TRADITION OF EXCELLENCE:
SAN FRANCISCO EMA FY 2007 RYAN WHITE CARE ACT TITLE I
COMPETING CONTINUATION APPLICATION NARRATIVE

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(NOTE: It is our understanding - based on information in the FY 2007 Title I Competing Continuation Guidance - that Tables of Contents for narrative and attachment sections will <u>not</u> count toward the FY 2007 application page limit.)

ADVANCING A TRADITION OF EXCELLENCE: SAN FRANCISCO EMA FY 2007 RYAN WHITE CARE ACT TITLE I COMPETING CONTINUATION APPLICATION NARRATIVE

1. SEVERE NEED

Introduction to the San Francisco EMA

Located along the western edge of the San Francisco Bay in Northern California, the San Francisco Eligible Metropolitan Area (EMA) is a unique, diverse, and highly complex region in terms of both geography and the nature and distribution of its people. Encompassing three contiguous counties - **Marin County** to the north, **San Francisco County** in the center, and **San Mateo County** to 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 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 (SF) EMA is unusual in part because of the dramatic difference in the size of its three member counties. While Marin and San Mateo Counties have a land area of **520** and **449** square miles, respectively, San Francisco County covers a land area of only **46.7** 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 and Washington, DC) in which the city's borders are identical to those of the county in which it is located. The unification of city and county governments under a single mayor and a single Board of Supervisors allows for a more streamlined service planning and delivery process in San Francisco, creating economies of scale that to some degree offset the high cost of doing business in the region.

The total 2003 population of the San Francisco EMA was estimated by the US Census Bureau at **1,695,211**.[1] This includes a population of **246,073** in Marin County, **751,682** in San Francisco County, and **697,456** in San Mateo County, with widely varying population densities within the three regions. While the population density of Marin County is **473** persons per square mile, for example, the density of San Francisco County is a stunning **16,096 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 **1,553** 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 American Indian (**0.4%**) populations. 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]

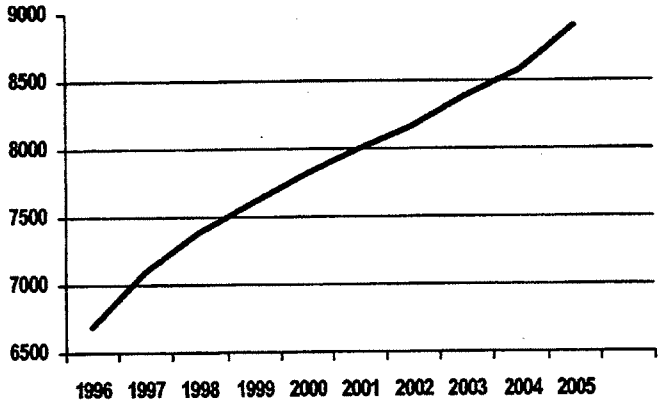
a) HIV/AIDS Epidemiology

i) HIV/AIDS Epidemiology Table - See **Table 1** in Attachment 1

ii) HIV/AIDS Epidemiology Narrative

Description of Current HIV/AIDS Cases: **Twenty-five years into the HIV epidemic, the three counties of San Francisco EMA continue to be devastated by the crisis of HIV - an ongoing tragedy that has exacted an incalculable human and financial toll on our region.** According to the State of California, as of December 31, 2005, a total of **30,196** cumulative AIDS cases had been diagnosed in the EMA, with just over **20.000** persons having died of AIDS.[5] Combined data for the EMA's three counties indicates that **10,941** persons were living with AIDS as of December 31, 2005, while another **11,698** individuals were estimated to be living with HIV, for a total of **22,639** persons living with HIV infection in the three-county region as of the end of 2005 (see Table 1 in Appendix A).[6] This represents an EMA-wide HIV infection incidence of **1,335.5** cases per 100,000 persons, meaning that **more than 1 in every 75 residents of the San Francisco EMA is currently living with HIV.** A total of **907** new cases of AIDS were diagnosed in the EMA between January 1, 2004 and December 31, 2005 alone, increasing the EMA's living AIDS caseload over that time by nearly **10%**.

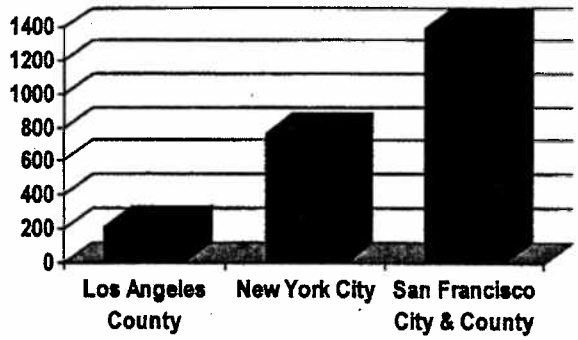
Figure 1. Number of Persons Living with AIDS in San Francisco - 1996 - 2005



At the epicenter of this continuing crisis lies the city and county of San Francisco, the city hardest-hit during the initial years of the AIDS epidemic. **Today, San Francisco continues to have the highest per capita prevalence of cumulative AIDS cases,[7] and AIDS remains the second leading cause of premature death in the city.[8]** The number of persons living with AIDS in San Francisco has increased by **33%** over the last decade alone - a percentage that does include more rapidly escalating non-AIDS HIV cases (see Figure 1).[9] Through December 31, 2005, a cumulative total of **26,522** cases of AIDS had been diagnosed in San Francisco, accounting for nearly **3%** of all AIDS cases ever identified in the US and **19%** of all AIDS cases diagnosed in California, despite the fact that San Francisco County contains only **2%** of the state's population. As of the end of 2005, just under **20,000** San Franciscans (**19,959**) were living with AIDS or HIV, representing **90%** of all those living with HIV and AIDS in the SF EMA, for a staggering citywide prevalence of **2,655** cases of HIV per 100,000. **This means that 1 in every 38 San Francisco residents is now living with HIV disease - an astonishing concentration of**

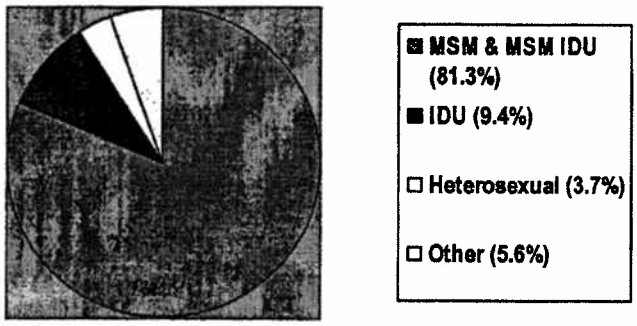
HIV infection in a city with a population of only 750,000. As of December 31, 2004, the incidence of persons living with AIDS per 100,000 in San Francisco County (**1,397.9** per 100,000) was over **five times** that of Los Angeles County (**213.4** per 100,000) and nearly **twice** that of New York City (**759.3** per 100,000) (see Figure 2).[10] The following sections provide information on the demographic components of the local HIV epidemic.

Figure 2. People Living with AIDS Per 100,000 Population as of 12/31/04 - Selected US Metropolitan Areas



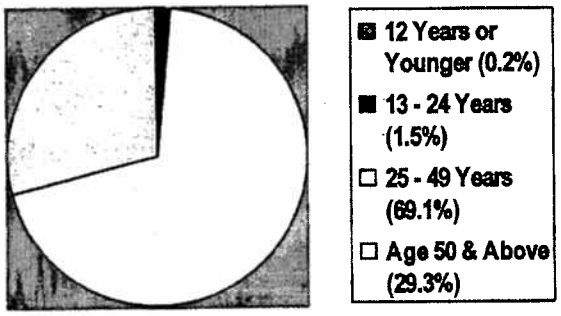
- ***Transmission Categories:*** **The most important distinguishing characteristic of the HIV epidemic in the San Francisco EMA involves the fact that HIV remains primarily a disease of men who have sex with men (MSM).** In other regions of the US, the impact on MSM has declined over time as other populations 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 (PLWH/A) has not been as high. Through December 31, 2005, fully **81.3%** of the population of persons living with HIV/AIDS in our region were MSM (**15,923**), including **15,923** men infected HIV through MSM contact only (**70.3%** of all PLWH/A) and **2,490** MSM who also injected drugs (**11.0%** of all PLWH/A) (see Figure 3). By comparison, only **28%** of PLWH/A in New York City as of December 31, 2005 were listed as being infected through MSM contact.[11] Factors underlying this difference include the large number 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 local transmission categories include injection drug users (**9.4%** of PLWH/A) and non-IDU heterosexuals (**3.7%**).

Figure 3. HIV Transmission Categories of San Francisco EMA Combined PLWA / PLWH Population as of December 31, 2005



- ***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 (**91.1%**) are men. Only **7.1 %** of all PLWH/A in the region are women - over **70%** of them women of color. However, the proportion of women with AIDS in the EMA is steadily increasing, with **9.4%** of new AIDS cases diagnosed among women between January 1, 2004 and December 31, 2005, versus an increase of **8.2%** in the entire AIDS-diagnosed population. Because of

Figure 4. Age of San Francisco EMA Combined PLWA / PLWH Population as of December 31, 2005



their high representation within the San Francisco population, **transgender people** also make up a significant percentage of PLWH/A, with at least **396** transgender individuals - the vast majority of them male-to-female - living with HIV or AIDS in the EMA as of December 31, 2005, a figure representing **1.7%** of the region's PLWH/A caseload.

- ***Current Age:***[12] **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 to 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 PLWH/A population as of December 31, 2005, close to **one-third (31.5%)** are age 50 or older (see Figure 4). Among persons living with AIDS, the percentage is even higher, at a dramatic **39.2%**, meaning that **two in every five persons living with AIDS in our EMA is age 50 or older.** Over the last year alone, the proportion of persons 50 and over increased by **2.7%** among persons living with AIDS and by **2.4%** among the combined HIV/AIDS population. 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 **66.9%** of the combined PLWH population, and **73.2%** of new AIDS diagnoses between January 1, 2004 and December 31, 2005. A total of **317** young people 13-24 are estimated to be living with HIV/AIDS, constituting **1.4%** of the EMA's PLWH/A population. Only **38** children age 12 and under are estimated to be living with HIV or AIDS in the EMA, and no new AIDS cases was diagnosed within this group between January 1, 2004 and December 31, 2005.

Figure 5. Ethnicity of People Living with AIDS in the San Francisco EMA as of December 31, 2005

- ***Race / Ethnicity:*** Reflecting the ethnic diversity of the EMA as a whole, the region's HIV/AIDS caseload is distributed among a wide range of ethnic groups. The majority of persons living with HIV and AIDS in the EMA are white (**63.45%**), with an additional **14.9%** of cases among African Americans; **14.7%** among Latinos; and **4.5%** among Asian / Pacific Islander groups (see Figure 5). **However, the percentage of new AIDS cases among persons of color is increasing rapidly.** While **35.6%** of all PLWA as of December 31, 2005 were persons of color, **45.6%** of all new AIDS cases diagnosed between January 1, 2003 and December 31, 2004 were among persons of color.
- **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, **14.9%** of combined PLWH/A populations in the San Francisco EMA are African American, meaning that **nearly three times** the number of African Americans are infected with HIV as their proportion in the general population. And while **63.4%** of all PLWH/A 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 only **4.5%** of PLWH/A cases. Latinos constitute **14.7%** of PLWA/PLWH cases, while making up **16.9%** of EMA residents. However, new HIV cases will soon create a disproportionate impact among Latinos as well. The disproportionate representation of HIV infection among African Americans is most dramatic among **women,** with African American women making up **43%** of all women living with HIV/AIDS in the EMA. However, the epidemic's most disproportionate impact remains among gay and bisexual men. Approximately **61,000** gay-identified MSM live in the San Francisco EMA, and an estimated **18,413** of them were HIV infected as of December 31, 2004. **This means that a startling 30% of all gay-identified MSM in the San Francisco EMA are already 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 CARE System: Compared to their proportion of HIV/AIDS cases, **women, persons of color, heterosexuals, and transgender people** are **over-represented** in the local CARE-funded system, with **whites** and **men** are **underrepresented** in CARE-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 CARE clients, although they are still the vast majority of clients served at **71.4%.** CARE 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, Title IV primarily serves young people and women, while Title III programs serve the full spectrum of clients, including the homeless, persons of color, women, and gay/bisexual men. **Twenty-two percent** of CARE clients in the San Francisco EMA are African American as compared to **15%** of all persons with HIV/AIDS in the EMA; in San Francisco, **63%** of all African Americans with HIV are receiving CARE services. Women are well served by CARE, with **11%** of CARE system clients being women, despite representing **7%** of the PLWH/A population. Heterosexuals represent **12%** of CARE clients but only **3%** of HIV cases. Transgendered people make up **3%** of persons served through the CARE system while making up **1.7%** of all persons living with HIV and AIDS in the EMA.

EMA Service Gaps: According to the recently completed 2006 Unmet Need Framework (see Section 7.ii), a total of **3,909** HIV-aware individuals in the San Francisco EMA are currently **not** receiving HIV primary care, representing **19%** of the region's total HIV-aware population. Another **2,000** persons with HIV or AIDS are believed to be **unaware** of their status, and therefore also not receiving HIV care. This means that close to **6,000** persons living with HIV/AIDS - roughly **26.5%** of the combined PLWH/A population - are out of care. Of the remaining **16,730** individuals, an estimated **8,047** receive CARE-funded services in the EMA, representing roughly **half** of the region's combined PLWH/A population in care, and **36%** of the overall PLWH/A population. Of those who are aware of their HIV status, at least **34%** are accessing CARE-funded medical services, according to data available through **Reggie,** the client database and registration system for San Francisco.

In 2005, the San Francisco EMA commissioned and completed a new **Comprehensive HIV/AIDS Health Services Needs Assessment,** which included in-depth client surveys completed by **607** PLWH/A in all three counties; a series of **11** population-specific focus groups; and a provider survey completed by **21** of the region's HIV/AIDS service organizations.[13] The Needs Assessment was instrumental in guiding FY 2007 prioritization and funding allocation decisions by the San Francisco HIV Health Services Planning Council. **Overall, 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.** On an EMA-wide basis, service categories for which more than **10%** of survey respondents reported **unmet needs** included: a) **employment assistance** (**10.7%** unmet need); b) **volunteer assistance with transportation** (**24.5%** unmet need); c) **legal services** (**10.9%** unmet need); and d) **consumer advocacy** (**11.5%** unmet need). In regard to housing, **45.1%** of survey participants reported currently being on a **housing waiting list,** while in relation to health care insurance, **17.3%** of San Francisco residents and **13.2%** of San Mateo County residents reported that they did not have health coverage of any kind, with **Latinos** being the group least likely to be uninsured, with **24.3%** of this group lacking health insurance (all participants in Marin County reported having health insurance). **Overall, the 2005 Comprehensive Needs Assessment found that by far the largest perceived service barrier in the San Francisco EMA was "reduced or discontinued services due to funding cuts," a challenge to service access reported by two-thirds (66.3%) of all survey respondents.**[14]

b) Impact of Co-Morbidities and Medicaid Funding on the Cost and Complexity of Providing Care

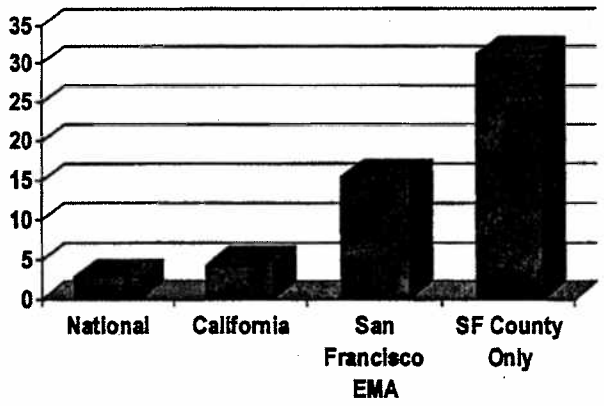
b.i) Quantitative Evidence on Co-Morbidities - See Table 2 in Attachment 1

b.ii) Narrative on Cost and Complexity of Providing Care

Sexually Transmitted Infection (STI) Rates: 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. In terms of **syphilis,** for example, the San Francisco EMA has been confronting a highly publicized epidemic that has been escalating for the past half decade, **rising more than 500% since 2000,** with a total of **363** new primary and secondary syphilis cases diagnosed in the EMA in 2004 alone, including **347** cases in the City of San Francisco.[15] Fortunately, local efforts to address the crisis have now begun to produce meaningful results, with calendar year 2005 marking first reduction in new syphilis cases in more than half a decade. In 2005, a total of **262** new primary and secondary syphilis cases were reported in the San Francisco EMA, **101** fewer than in 2004, representing a **28.7%** annual reduction.[16] Within the City of San Francisco, a total of **248** new syphilis cases

were reported in 2005, 99 cases fewer than in 2004, for a **28.5%** annual reduction.[17] However, despite our progress, 2005 syphilis incidence rates of **15.5** cases per 100,000 for the EMA as a whole and **31.2** cases per 100,000 in San Francisco are **4 times** and **7 times higher,** respectively, than the 2004 statewide rate of **4.3** cases per 100,000, and **6 times** and **12 times higher,** respectively, than the national syphilis rate of **2.7** cases per 100,000 in 2004 (see Figure 6).[18]

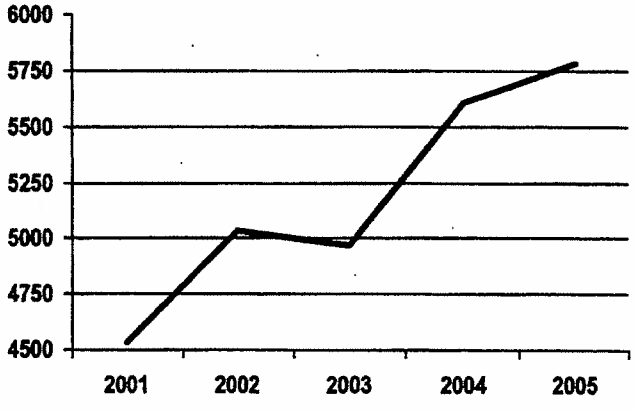
Figure 6. 2005 New Primary & Secondary Syphilis Cases Per 100,000 Population



A comparable epidemic of **gonorrhea** is also underway in our EMA. A total of **2,770** new gonorrhea cases were identified in the San Francisco EMA in 2005, **an alarming increase of 13% over the 2,445 new cases diagnosed in 2004, and 33% over the 2,084 cases diagnosed in 2003.**[19] **2,463** of these new cases occurred in the City of San Francisco. The EMA-wide incidence of **163.4** cases per 100,000 is nearly **50% higher** than the 2004 national rate of **113.5** cases per 100,000 and more than **75% higher** than the California rate of **92.6** cases per 100,000 (see Figure 7).[20] San Francisco's 2005 incidence of **309.9** cases per 100,000 is **nearly three times** the national rate and is **335% higher** than the statewide rate.[21] Many of the EMA's new gonorrhea cases are occurring among **young women aged 15 – 24,** who accounted for **269** cases in 2005. The gonorrhea rate of **658.6** per 100,000 15-24-year-old women in San Francisco is **70% higher** than the statewide rate of **387.7** per 100,000.[22]

San Francisco EMA's **chlamydia** rates also continue to rise, although they remain comparable to national and statewide averages. A total of **5,781** new cases of chlamydia were diagnosed in the EMA in 2005 - a **16% increase** over the **3,970** cases diagnosed in 2003 and a **28%** increase since 2001 (see Figure 8).[23] The 2005 EMA-wide chlamydia incidence stood at **341.0** per 100,000, while the rate for the City of San Francisco was at **477.7** cases per 100,000 (**3,797** new cases in 2005 alone).[24] By comparison, the 2005 incidence for California was **352.1** cases per 100,000 and **319.6** per 100,000 for the nation.[25]

Figure 8. Annual Reported Chlamydia Cases - San Francisco EMA - 2001-2005



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.**[26] 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.[27] 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.**[28] Such studies suggest that the total of cost treating new STIs in the SF EMA may be as high as **$26.7 million** per year, including an estimated **$5.5 million** to treat STIs among persons with HIV, while another **$75 million** in costs may result from the need to treat persons infected with HIV as a result of transmission facilitated through other STIs.[29]

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 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.[31]

Figure 9.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs[30]

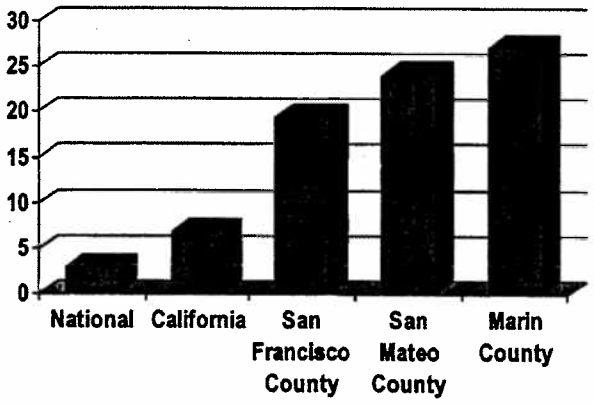
County	Hourly Wage Needed to Rent a Two-Bedroom Apartment at HUD Fair Market Rent
Marin County, CA	$ 29.54
San Francisco County, CA	$ 29.54
San Mateo County, CA	$ 29.54
Ventura County, CA	$ 28.12
Orange County, CA	$ 26.77
Santa Cruz County, CA	$ 25.83
Alameda County, CA	$ 25.75
Contra Costa County, CA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

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, and necessitating the continued prioritization of housing services by the San Francisco HIV Health Services Planning Council. According to the National Low Income Housing Coalition's authoritative *Out of Reach 2005* report, for example, Marin, San Francisco, and San Mateo Counties are currently **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 9).[32] The San Francisco metropolitan region also ranks as the **most expensive metropolitan region in the US** in terms of the same statistic.[33] Meanwhile, the San Francisco Metropolitan Area also 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".[34] The 2006 HUD Fair Market Rent for a two-bedroom apartment in the San Francisco Metropolitan

Area currently stands at **$1,536** per month - an amount **2.3% higher** than the second highest metropolitan area of Stamford-Norwalk, Connecticut.[35]

Additional problems complicate the location and retention of safe, adequate, and affordable living spaces in the San Francisco EMA, especially among persons living on low incomes who make up the vast majority of local PLWH/A. The City of San Francisco, for example, has an extremely high proportion of **older housing structures** that provide less safe and adequate shelter opportunities, especially for persons with low incomes. According to the 2000 Census, fully **one-half (49.9%)** of all housing structures in San Francisco were built in **1939 or earlier**, while another **one-quarter (24.7%)** were built **between 1940 and 1959**, meaning that **74.6% of all housing structures in the city were built before 1960.**[36] By contrast, only **9.4%** of housing structures in the entire State of California were built in 1939 or earlier, and **15.0%** of structures nationally were built before this date.[37] Partially as a result of this, San Francisco has an extremely large percentage of housing units that lack even the most basic facilities. Fully **2.1%** of all housing structures in San Francisco (**6,803** total buildings) lack complete plumbing facilities - **three times** the statewide rate of **0.7%** - while **3.7%** of all structures in San Francisco (**12,285**) lack kitchen facilities, a figure **3.7 times higher** than the statewide rate of **1.0**.[38] 2000 Census figures also indicate that the percentage of rental units in the San Francisco EMA requiring **$1,500 or more** in monthly gross rental payments is significantly higher than the State of California or the nation, resulting in reduced housing opportunities for persons with low incomes. For example, **19.4%** of rental units in San Francisco County, **24.1%** in San Mateo County, and **27.1%** in Marin County require a gross rent of **$1,500 a month or more**, versus percentages of **6.8%** for California and **2.9%** for the nation as a whole (see Figure 10).

Figure 10. Percentage of Total Rental Units Costing $1,500 Per Month Gross Rent or More - 2000 Census



The City of San Francisco has made great strides in its efforts to battle chronic homelessness, but still faces an uphill battle due to both the shortage of low-income housing and the large tourist populations on which many homeless people have historically relied for income. 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.[39] This number represents an impressive **28%** decline from the **8,640** homeless persons identified during the previous count in October 2002 - a result attributed in part to the aggressive creation of expanded permanent supportive housing facilities.[40] However, 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.**[41] 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.[42] 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.

Meanwhile, the Marin County Community Inter-Action Partnership reported that in calendar year 2002, a total of **8,265** unduplicated households and **15,518** individuals were homeless or at risk of becoming homeless, and that at least **2,932** individuals had experienced an extended period of homelessness at some point during the year, including at least **598** children.[43] At the same time, according to the recently developed 10-year HOPE Plan to End Homelessness in San Mateo County, there are an estimated **7,862** homeless individuals living in the region at any one time, in addition to an estimated **26,000** who the report names as being "at risk" of homelessness.[44] Combining this data, we arrive at a rough estimate of **26,640** individuals experiencing homelessness at some point during the calendar year within the San Francisco EMA - the midpoint of a range from **22,434** to **30,846** individuals - 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[45] to an astounding **41%** among marginally housed adult MSM.[46] 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[47] to **68%** among gay and bisexual male teens who enter homeless youth centers.[48] 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 **10%** in 2005, although this percentage has declined significantly from a high of **14%** in the year 2000.[49] **Such findings have been borne out in San Francisco's 2005 Comprehensive HIV/AIDS Needs Assessment, which found that 45.1% all respondents were currently on a housing waiting list and that the percentage of respondents who were able to rent a house or apartment decreased from 53.8% in 2003 to 40.6% in 2005.** Among CARE clients, approximately **7%** are **currently** homeless - including persons living in emergency shelters - and another **19%** are incarcerated, in a drug or alcohol rehabilitation program, hospitalized, or living temporarily with a friend of family member.[50]

The additional burden of **costs** which homelessness places on the local system of care is difficult to calculate, but add 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.**[51] 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.[52] 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 the cost of overnight jail stays.[53] Overall, we estimate that the total costs of homelessness add at least an additional **$19.02 million** to the overall cost of care for HIV-positive individuals within the EMA – costs that do not take into account the higher rates of HIV infection that occur among homeless populations.[54]

Insurance Coverage: Based on findings of the 2003 California Health Interview Survey, an estimated **16.3%** of San Francisco EMA residents are believed to be without **any** form of insurance coverage - including Medicaid - for a total of **341,492** uninsured individuals in our region.[55] This includes an estimated **18.1%** uninsured in San Francisco; **16.7%** uninsured in San Mateo County; and **9.0%** uninsured in Marin County.[56] **The lack of health insurance is a significant barrier to care, placing incalculable financial burdens on the system, particularly in an area such as the San Francisco EMA, which has extremely high medical costs.** According to current Reggie data, **50%** of San Francisco CARE system clients are covered by Medicaid, but **27%** 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 much higher than the EMA-wide uninsured rate among 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. The 2005 HIV Needs Assessment suggested considerable progress in terms of San Francisco's efforts to enroll more persons with low incomes in Medi-Cal and other public benefits programs, with the proportion of respondents who said they had some form of insurance rising from **58%** in 2002 to **83.7%** in 2005.[57] We estimate that the **cost** to the system of serving uninsured and indigent populations living with HIV is at least **$90.4 million** annually, based on an average **27%** uninsured rate among persons living with HIV/AIDS in care (n=**4,520**) at an estimated annual average cost of **$20,000** per person for HIV treatment and medications.

Poverty: The problem of homelessness is closely tied to that of **poverty**, and presents another daunting challenge to the HIV care system. Using 2000 Census data, we estimate that **808,917** individuals in the San Francisco EMA are living at or below 300% of Federal Poverty Level, which translates to **47.72%** of the overall EMA population lacking resources to cover all but the most basic expenses.[58] **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 **66.5%** of all persons living with HIV and AIDS in the San Francisco EMA (n=**14,725**) are living at or below 300% of Federal Poverty Level (FPL) - including persons in impoverished households - and that **100%** of CARE-funded clients are living at or below 300% of poverty.[59] Reggie data reveals that **53%** of active CARE clients in San Francisco are currently living on incomes of under **$10,000 per year**, and **18%** are surviving on incomes of less than $5,000 per year. **Even more dramatic is the fact that the 2005 HIV/AIDS Health Services Needs Assessment found that 96.2% of those sampled were living on annual incomes at or below 300% of FPL**, with nearly **half** of respondents reporting annual incomes below 100% of FPL, and only **14.4%** of respondents reporting annual incomes above 150% of FPL. As those whom the Ryan White CARE Act was created to serve, HIV-infected persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **$131 million** in Title I and non-Title I HIV-related expenditures in the San Francisco EMA each year.[60]

b.iii) HIV-Related Medicaid Expenditures in the San Francisco EMA

Medi-Cal is the name given to the State of California's Medicaid program. Medi-Cal serves as an indispensable link in the chain of support for meeting the needs of our region's poorest HIV-infected residents. In documents provided by California for this year's Title I application, the State reports a total of **$103,801,256** in HIV Medi-Cal expenditures for the three counties in the San Francisco EMA for calendar year 2005.[61] Just over **two-thirds (68.4%)** of annual HIV Medi-Cal expenditures in the San Francisco EMA are for **HIV-related medications**

(**$71,010,466**); another **11.9%** (**$12,379,370**) are for **inpatient care**; and **7.5%** (**$7,766,417**) are for **outpatient care.**[62] The remaining **12.2%** are dispersed among several additional categories.

A total of **5,124** HIV-positive individuals in the San Francisco EMA are listed as Medi-Cal recipients by the State of California for the first half of 2006.[63] This represents an increase of **nearly 6%** over the **4,836** beneficiaries reported for the first six months of 2004, attesting to our continued success in identifying, bringing into care, and successfully enrolling in Medicaid our region's poorest HIV-infected populations. Our EMA's HIV-positive Medi-Cal beneficiaries make up **17%** of all HIV-positive Medi-Cal recipients living in the 16 California counties that receive Title I dollars (**29,977** total recipients). By contrast, the total population of the San Francisco EMA (1,753,533) represents only **6.7%** of the population of the 16-county region (26,328,625), meaning that the percentage of HIV-positive Medi-Cal beneficiaries in our EMA is **2.5 times higher** than for the 16-county region as a whole.[64]

The San Francisco HIV Health Services Planning Council closely analyzes changes in Medi-Cal data each year and takes this information into consideration in making its annual allocation of Title I primary medical care funding. The Council considers a wide range of counterbalancing factors, such as the proportion of persons newly enrolled in Medi-Cal to the number of new annual HIV cases, and the extent to which the growth in recent immigrant and other non-Medicaid-eligible low-income populations may be outpacing the growth in Medi-Cal enrollments and reimbursements. The Council also explores the extent to which reduced Medicaid reimbursements in California are driving local providers out of care, and increasing the difficulty even Medicaid-enrolled individuals sometimes have in accessing care.

c) Assessment of Populations with Special Needs

As a region with a high degree of diversity and complexity, the San Francisco EMA is home to a wide range of populations with special needs, including women, youth, and transgender people; members of distinct ethnic, cultural, and linguistic groups; and members of diverse social and behavioral communities. These groups require sensitive and specialized interventions in order to involve and retain them in care; meet service needs; and empower them to become their own best care self-advocates. **The challenge of effectively meeting the needs of special populations within 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** special needs populations for special mention, each of which is described briefly below: **1)** Men of color who have sex with men; **2)** White men who have sex with men; **3)** Injection drug users; **4)** Homeless individuals; **5)** African Americans; and **6)** Latinos. All of these groups have high incidences of HIV infection, resulting in increased costs to the local system of care.

Special Population # 1: 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 **81.3%** of all persons living with HIV and AIDS as of December 31, 2005, including MSM who inject drugs.[65] A total of **8,838** of these individuals - or **48%** of the HIV-infected MSM population of the EMA - are estimated to be persons of color, most of them **African Americans** and **Latinos.** This is a severely disproportionate representation, since MSM of color make up only an estimated **37.8%** of the EMA's total MSM population. 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 **$99,435,000**.[66]

Special Population # 2: White Men Who Have Sex with Men: As noted above, MSM account for **81.3%** of all persons living with HIV and AIDS in the San Francisco EMA, including MSM who inject drugs. A total of **9,575** of these individuals - or **52%** of the HIV-infected MSM population of the EMA - are estimated to be white MSM. As described in Section 1.a.ii above, gay-identified MSM may have an overall HIV seroprevalence rate as high as **30%**, resulting in a continuing high risk of HIV infection throughout this population. Significant threats pointing to a continuing HIV caseload rise among this population include the growing rates of methamphetamine use among white MSM; high syphilis and rectal gonorrhea rates in MSM communities; and growing HIV infection rates among both white MSM and MSM of color. Young MSM between 20 and 24 years of age account for **60%** of diagnosed youth AIDS cases in the EMA, the majority of them among white MSM. White MSMs have lower levels of unmet needs than MSM of color because the population as a whole tends to have been in care longer. Prior needs assessments have found that individuals with **co-morbidities** – such as hepatitis C – have a higher incidence of delaying or not seeking care than those without co-morbidities. Many white MSM are also closeted and/or bisexual, and fear that their behavior will be revealed if they seek testing or services. In order to reach all segments of this population, services must be **confidential** and must be sensitive to the needs of MSM residing in heterosexually dominant communities. The annual **cost** of providing HIV-related services to white MSM is estimated at **$80,430,000**.[67]

Special Population # 3: Injection Drug Users: Injection drug users (IDU) are a significant risk group in San Francisco - a group whose numbers are rising due to the expanding number of individuals injecting methamphetamine. A total of **4,608** IDU were estimated to be living with HIV or AIDS as of December 31, 2005 – including MSM IDU - representing roughly **28%** of the EMA's total estimated IDU population, although the size of the population may be underestimated slightly due to rising meth injection rates. **This means that the HIV infection rate among IDUs is higher than among white MSM.** Again reflecting the epidemic's disproportionate impact on men who have sex with men, the total number of MSM IDUs living with HIV/AIDS in the EMA is **higher** than the total number of non-MSM IDUs (**2,490** MSM cases as compared to **2,118** non-MSM cases). **Women** are also disproportionately affected by injection drug use both through direct transmission and via heterosexual transmission through an injecting male partner. Injection drug users require specialized, tailored outreach and support in order to access and utilize primary HIV care. People with a history of injection drug use - in part as a result of chaotic life circumstances - demonstrate episodic use of health care and frequent utilization of emergency departments for treatment of conditions such as soft tissue wounds, infections, and overdoses. High rates of **mental illness** among this population indicate a need for integrated mental health and substance abuse treatment services for the triply diagnosed - services which have begun to be significantly expanded and refined through the Centers of Excellence program. Many HIV-infected IDU are not ready or willing to enter drug treatment at the time of diagnosis, creating a need for services which provide care to injection drug users in spite of their drug-using patterns. Active IDU in care require special monitoring and tailored

care, as interactions between combination therapies and injected substances can create health complications. The annual **cost** of providing HIV-related services to injection drug users is estimated at **$62,208,000.**[68]

Special 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 **1,584** HIV-infected homeless individuals are estimated to be living with HIV or AIDS in the San Francisco EMA (based on an overall 7% homelessness rate among PLWH/A – see p. 13 above), 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 **$19,000,000.**[69]

Special 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, 2005, a total of **3,371** African Americans were living with HIV/AIDS in the EMA, representing **15.1%** of the region's HIV-infected population, despite the fact that only **5.3%** of the EMA's population is African American. At least **40%** 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 2003 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; racial discrimination; 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 – is expected to make a significant contribution toward addressing this discrepancy.** The annual **cost** of providing HIV-related services to African Americans is estimated at **$41,256,000.**[70]

Special 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 living with HIV and AIDS in the EMA as of December 31, 2005 were Latino/a, **20.9%** of new AIDS cases and **31.1%** of estimated new HIV infections between January 1, 2004 and December 31, 2005 were among Latino/as, with a total of **3,331**

Latino/a PLWH/A estimated to be living in the EMA as of December 31, 2005. According to the 2005 San Francisco HIV Epidemiology Report, Latinos represent **46%** of adolescent AIDS cases 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 **$41,976,000.**[71]

d) Unique Service Delivery Challenges

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 a severe economic and service 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 **four** broad categories: **1)** The growing population of persons living with HIV infection, including individuals with complex and multiple needs; **2)** Escalating co-morbidities which threaten to swamp the system and create overwhelming demands on care providers; and **3)** The concentration of HIV and AIDS cases within a relatively small geographic area, especially in the case of San Francisco. 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 **22,639** persons living with HIV and AIDS as of December 31, 2005 represent **75%** of the total number of AIDS cases **ever diagnosed** in the San Francisco EMA, and is **13% more** than the 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. **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, and should not become a reason for penalizing the EMA because of State HIV reporting policies over which our region has no control.** Preserving health and lengthening span of life is the primary intent of the Ryan White program, and we believe the San Francisco EMA has done an

exemplary job of living up to the goals and precepts of the CARE Act in helping ensure a better, more stable, and more productive life for **all** persons living with HIV and AIDS in our region.

In addition to these factors, local HIV-infected populations 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 reveal that **42.5%** 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 clearly 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.[72]

The facts of the local epidemic are staggering. **Sixty-five percent** of persons living with HIV and AIDS and **one hundred percent** of persons in the CARE system are living at or below 300% of federal poverty level.[73] **Twenty-seven percent** of persons with HIV have no form of health insurance.[74] **One in ten** persons diagnosed with AIDS in the EMA are homeless.[75] As many as **half** of MSM living with HIV in the EMA suffer from depression.[76] **Thirty percent** of local PLWH are active substance users.[77] **One in seven** persons with HIV in the EMA speak a primary language other than English.[78] **Thirty percent** of gay-identified men in the San Francisco EMA are HIV-infected.[79] **Thirty-five percent** or more of transgender people are believed to be HIV-infected, including **over half** of all African American male-to-female transgender people.[80] 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 2003 San Francisco HIV Needs Assessment, for example, were asked **where** they had received their original AIDS diagnosis, and **24.5%** of respondents reported that they had been diagnosed with AIDS **outside** the EMA, and had moved to the region to receive care.[81] This percentage is believed to be similar for persons living with HIV.

Additionally, large numbers of **immigrants** - many from Asia, and many at high risk for HIV due to pre-existing conditions such as tuberculosis – continue to enter the EMA at the rate of approximately **20,000** each year. Because members of these groups frequently speak a single language other than English, they are harder to reach than members of the general population. They are also harder to bring into care, in part because of fears of deportation and a mistrust of western medicine - a mistrust that permeates the African American community as well. In San Mateo County, a large migrant farm worker population along the southwestern edge of the county creates a further risk pool that is difficult to reach.

Escalating Co-Morbidities: Section 1.b above describes several co-morbidities critical to the complexity of providing care in the San Francisco EMA. By no means, however, are these the only key issues contributing to the growing complexity of the HIV epidemic in San Francisco, and the ongoing demand this places on the CARE Act-funded service system.

The problem of **substance use**, for example, plays a central role in the dynamics of the HIV epidemic throughout our EMA, 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 PLWH 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.,**[82] while drug poisoning/overdose is the city's **third** leading cause of premature death.[83] 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.**[84]

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,[85] and recreational crystal use has been linked to **30%** of San Francisco's new HIV infections in recent years.[86] Because methamphetamine is frequently injected, the drug presents a threat similar to that of heroin in terms of its ability to transmit HIV via needle use. A study conducted in 2003 by the San Francisco Department of Public Health among **347** men attending late-night MSM venues in San Francisco found that **46%** of participants reported a history of injection drug use, nearly all of which (**94%**) involved injection of **methamphetamines.**[87] **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 Special Populations section above). However, only about **2,500** heroin users have access to methadone maintenance treatment. In addition, there is a rapidly rising incidence in the use of so-called "club drugs" such as methylenedioxymethamphetamine (**MDMA**), also known as **"ecstasy"**; **ketamine**, also known as **"K"** or **"Special K"**, a dissociative anesthetic used primarily in veterinary practice; and gamma-hydroxybutyrate (**GHB**), which in increasing doses progressively produces amnesia, drowsiness, dizziness, euphoria, seizures, coma, and death.[88] **According to the Office of National Drug Control Policy, San Francisco had the highest rate in the nation of club drug-related emergency room visits in 2002, with 59 visits per 100,000 population.**[89]

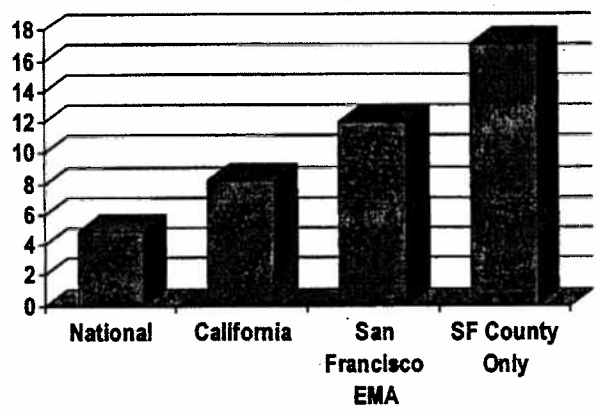
The costs associated with the substance addiction epidemic in the San Francisco EMA add significantly to the local burden of HIV care. According to the National Office of Drug Control Policy, the nationwide societal costs of drug abuse in the year 1998 alone totaled **$143.4 billion.**[90] The National 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.**[91] 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.[92]

Injection drug use in the San Francisco EMA is closely related to the growing local epidemic of **hepatitis C**. As of mid-2003, 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 within urban areas of **916.81** per 100,000.[93] 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,[94] while Marin County reported **145** new cases in 2003, nearly double the **87** cases reported in 2002.[95] Because it is a blood-borne infection, hepatitis C is also closely tied to the injection drug

use crisis, 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.[96] 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.**[97] 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.**[98] **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 new 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 **204** new cases of TB diagnosed in the San Francisco Metropolitan Area in 2004 (the most recent reporting period), representing an EMA-wide incidence of **12.0** cases per 100,000.[99] In San Francisco, the incidence is even higher, at **17.1** cases per 100,000. **The city's tuberculosis incidence rate is more than 50% higher than the statewide rate of 8.2 cases per 100,000, and 250% higher than the national rate of 4.9 cases per 100,000** (see Figure 11).[100] Rates of new TB infection in San Francisco are highest among Asian/Pacific Islander populations (**4.1** cases per 100,000), reflecting the disease's heavy impact on recent immigrant populations. In 2003, **10%** of persons with reported TB infection were also co-infected with HIV. Treatment for cases **of multidrug-resistant tuberculosis** are especially high, 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.[101]

Figure 11. 2004 New Tuberculosis Cases Per 100,000 Population



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 2002 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.[102] In part because of the allure of the Golden Gate Bridge, San Francisco also has one of the nation's highest rates of both suicide and

teen suicide, with a total of **211** suicides reported in the city in 2002 alone – the last year for which statistics are available.[103] In fact, the rate of suicide per capita in San Francisco is **twice as high** as the city's homicide rate.[104] 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%.**[105] 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.[106]

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 38** residents of the city is currently living with HIV disease, including as many as **one out of every three** 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.

San Francisco's extremely high population density also contributes to an environment in which HIV infection is able to flourish. The city includes a high proportion of gay and bisexual men, and San Francisco has long been a magnet for runaway youth and for young people seeking alternative communities and ways of living. The city's high cost of living results in a large homeless population which is in turn at increased risk of HIV. Large numbers of tourists visit the city each year (San Francisco is the nation's second largest tourist destination after Orlando, Florida) and many of them engage in high-risk behaviors while in the city. All of these factors result in a **concentrated risk pool** within which new HIV cases are continually developing. This means that the system of care must not only struggle with unprecedented HIV/AIDS caseloads, but that this population will **continue to increase** over the coming months and years. **This makes it essential that the San Francisco system of care at least retain its existing funding levels in order to avoid an even more serious range of human and health consequences over the coming years.**

2. PLAN FOR FY 2007

a) FY 2007 Implementation Plan Table - See Table 3 in Attachment 1.

b) FY 2007 Implementation Plan Narrative

The FY 2006 Ryan White Title I Implementation Plan for the San Francisco EMA represents a thoughtful, innovative, client-centered, and cost-effective strategy for meeting the most critical care and support needs of complex, low-income HIV-infected individuals in our region. At a time of rising costs, declining resources, and expanding HIV-infected

populations, the Plan seeks to ensure a **seamless, comprehensive, and culturally competent system of care** which is focused on the complementary goals of: **a) reducing inequities and disparities** in care access and outcomes, and **b) ensuring parity and equal access** to HIV/AIDS primary medical care and support services for all residents of our region. The Plan strikes a balance between providing an **integrated range of intensive health and supportive services** for complex, severe need, and multiply diagnosed populations, and expanding and nurturing the **self-management and personal empowerment** of all persons living with HIV. The Plan incorporates the perspectives and input of a broad range of consumers, providers, and planners from across our region, as well as findings of key data sources including the 2005 Unmet Needs Framework, the 2005 Comprehensive HIV/AIDS Health Services Needs Assessment, and the EMA's new 2006-2009 Comprehensive HIV Health Services Plan. **The FY 2006 Title I Implementation Plan is a critical step forward in preserving and advancing a tradition of HIV service excellence in the San Francisco EMA.**

The combined FY 2007 Title I Implementation Plan requests a total of **$33,837,485** in Formula, Supplemental, and MAI funding to allow our region to continue to meet escalating client needs in an effective and strategic manner. Direct service allocations make up **92.7%** of this total request, for a total of **$31,381,326**. Another **$461,786** supports the work of the San Francisco HIV Health Services Planning Council; **$302,500** supports EMA-wide quality management activities; and **$1,691,874** supports administrative costs for the Grantee at the stipulated **5%** level. Reflecting AIDS prevalence levels in our EMA's three counties, a total of **$2,253,143 (7.2%** of FY 2007 direct service dollars) supports HIV client services in **San Mateo County**, while **$1,022,406** supports direct HIV services in **Marin County (3.3%** of FY 2007 service dollars). The remaining service allocation supports persons living with HIV and AIDS in the city and county of San Francisco.

Linking Needs Assessments, Plans, and Service Priorities: The proposed FY 2006 Plan is **fully linked and integrated** with all key data sources, documents, and service plans for our region, including: a) the EMA's new 2006-2009 Comprehensive HIV Health Services Plan; b) last year's Comprehensive HIV/AIDS Needs Assessment; and c) a range of additional data reports and data describing critical needs for the local system of care (see Section 5.b below). The **three-year Comprehensive Plan** centers around a series of **12** broad systemic goals and **31** specific three-year objectives, each of which includes a series of **time-phased action steps** that set clear benchmarks for the attainment of specific tasks. **All of the goals, objectives, and action steps contained in the Comprehensive Plan were reviewed and utilized by the Planning Council during the prioritization and allocation process, and played a critical role in shaping the FY 2007 Plan.** For example, Objective # 4.4 of the Comprehensive Plan 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." The Planning Council used this mandate to provide continued strong, non-Title I fiscal support for one of the EMA's most innovative Centers of Excellence – the **Forensic AIDS Project**, providing jail-based health services and post-release treatment and care linkage services to incarcerated persons with HIV. Objective # 8.1, of the Comprehensive Plan, calling on the EMA to "continue to ensure that persons with HIV...are screened for benefits eligibility, have access to benefits assistance, and are referred to appropriate alternative providers as needed..." led to continued support for benefits counseling and legal services to ensure that all available resources to complement and augment Title I funds are fully maximized. **The San Francisco EMA is also currently building upon several planning-related objectives in the**

Comprehensive Plan by convening a new San Francisco HIV Health Planning Work Group, whose goal is to assess, anticipate, and plan for changes in both the HIV system of care and the existing structure of public and private support for HIV/AIDS services. The Work Group has begun to shape a new model of "HIV Health" which will almost certainly push our EMA even further toward a fully integrated, condensed model of care.

Findings of the 2005 Needs Assessment are also referenced throughout this application, and have been used to develop an implementation plan that responds to recently identified client needs. Other documents that have helped guide the Planning Council's decision-making this year include the new San Francisco HIV/AIDS Epidemiology Report for 2005;[107] a summary report on regional client characteristics and service utilization patterns collected through **Reggie**, San Francisco's centralized client intake and registration system;[108] and a series of Service Category Summaries prepared by all three EMA counties describing the nature, impact, and organization of each Title I-funded service category, along with detailed information on providers and sources of funding for each funded service.[109]

Support for HRSA Core Services: The majority of proposed FY 2007 service expenditures - **60.8%** of total requested service dollars (**$19,091,146**) - supports the provision of direct care services in HRSA-identified **core service categories.** Of the total direct service request, **$7,199,634** is requested for **primary medical care** services, representing nearly **one-fourth (23%)** of our total FY 2007 direct service budget. This includes support for ambulatory care services delivered in community and institutional settings as well as our **seven** regional **Centers of Excellence** that build upon and enhance San Francisco's existing, highly successful integrated services approach to care. Additional HRSA core categories funded through the FY 2007 Title I Plan include: a) **Mental Health Services**, including crisis, outpatient, and residential mental health services; b) **Case Management**, including standard, integrated, and residential case management; c) **Oral Health**; and d) **Substance Abuse Treatment**, including residential and outpatient substance abuse treatment and drug detoxification services. All six HRSA core categories are included in the **top ten** service priorities for the San Francisco EMA, and **five of the top six** EMA service priorities are HRSA core categories. This includes **AIDS Pharmaceutical Assistance**, which is the **# 2 priority** of the Planning Council this year. However, because the State of California has long maintained one of the strongest and most comprehensive AIDS Drug Assistance Programs (ADAPs) in the U.S., and because of our EMA's success in reaching Medi-Cal eligible populations and enrolling them in care, our EMA does **not** request Title I funds to support AIDS Pharmaceutical Assistance, despite the fact that the service is highly prioritized by the Planning Council.

Providing Access to the Continuum of Care for Communities with Growing Prevalence and Persons Not in Care: The most critically affected and fastest-growing HIV-infected population in San Francisco continues to be **multiply diagnosed, hard-to-reach, and persons with severe need** who require intensive support in order to stabilize their lives and to enter and remain in care. In mid-2003, the San Francisco EMA began a long-term strategic planning process designed to develop a new approach to HIV care in order to effectively meet the needs of these growing populations through **multidisciplinary service centers** located directly within the neighborhoods in which these populations lived. The process was in part was simultaneously designed to address the rising **cost** issues associated with care for multiply diagnosed and complex populations by creating single-source points of client contact in which services could be easily integrated and streamlined, and economies of scale could be realized.

The result of this two-year planning process has been the Centers of Excellence (CoE) program – a highly innovative network of seven HIV service centers, five of them supported through Title I funds, that are specifically designed to involve and retain complex, hard-to-reach, and multiply diagnosed populations in care. Initiated in November 2005, the three-part goal of the Centers of Excellence program is to: a) provide better health outcomes and improved quality of life for persons living with HIV/AIDS who have severe needs and/or are members of special populations; b) ensure that clients have seamless access to primary medical care and critical support services; and c) ensure that persons currently not in care are linked to and maintained in health care. Through the CoE program, our EMA and Planning Council have created a system in which the complex needs of hard-hit HIV sub-populations can be addressed within the context of **one-stop community-based centers** in which **multidisciplinary teams** provide high levels of HIV specialist medical care, integrated with a variety of additional on-site services designed to stabilize individuals and maintain them in treatment. Key service components augmenting medical care include: case management; psychiatric assessment; treatment adherence assistance; peer advocacy; access to emergency housing; outpatient mental health and substance use assessment and treatment; and support in obtaining transportation, food, and household goods. All CoEs also incorporate **prevention with positives** services, and are fully linked to HIV counseling and testing centers. Because they are **fully integrated** into the communities they serve, and provide culturally competent neighborhood-based services which are accessible and comfortable for consumers, the CoEs offer a highly effective approach to providing access to the continuum of care for communities with growing prevalence and who are not in care. **The San Francisco Centers of Excellence program has already begun to attract nationwide attention, with San Francisco's HIV Health Services Director, Michelle Long, receiving HRSA's 2006 Title I Hank Carde Award for Metropolitan Services, in part for her development of the CoE model.** Requested funds for the Centers of Excellence program in FY 2007 - scattered among a range of Title I service categories - will enable our EMA to provide at least **93,510** total units of service that reach an estimated **2,125** individuals who are members of severe need populations.

Addressing the Needs of Special Populations: The proposed FY 2007 Implementation Plan allows our EMA to reach and serve virtually **all** special populations in our diverse region. For example, our program's emphasis on **substance abuse** and **mental health** allows us to stabilize and bring into care a wide range of diverse groups facing chemical addiction and psychological challenges, including homeless men and women, injection drug users, and young people. **Minority AIDS Initiative** funds allow 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. **Our Centers of Excellence program provides a special opportunity for high-need and multiply diagnosed populations to enter and remain in care on a long-term basis.** The Centers are specifically tailored to **severe need populations,** defined by the San Francisco HIV Health Services Planning Council as persons who are: a) disabled by HIV/AIDS or with asymptomatic HIV diagnosis; b) substance dependent and/or mentally ill; and c) living in extreme poverty, with documentation of annual adjusted gross income equal to or less than **150%** of Federal Poverty Level. **Special populations** in regard to severe need groups are defined as those that specifically face **unique or disproportionate barriers to care,** such as individuals with linguistic or cultural barriers, individuals being released from incarceration settings, members of ethnic minority populations with low rates of HAART use and adherence, and transgender individuals. Our **seven** Centers of Excellence - including the **five** directly

supported through Title I funds - **all** provide tailored, multidisciplinary services to severe need and special populations, including the Title I-funded **Mission Center of Excellence** (Latino/Hispanic populations); the **Southeast Partnership for Health** (African American populations); and the **Women's Center of Excellence** (HIV-infected women). In addition, the **two** CoEs **not** supported through Title I funds also provide specialized support to special populations, specifically the **Native American AIDS Project** and the **Forensic AIDS Project**.

Encouraging PLWH to Remain in Primary Care and Adhere to HIV Treatments: The San Francisco HIV service system ensures that comprehensive treatment education, adherence, and support services are incorporated into **all** Title I-funded primary medical care and case management programs, and that client contact staff receive ongoing education in helping clients remain in care and on treatment. The Centers of Excellence program is in part specifically designed to provide community-based, multi-service contexts through which consumers feel more at home accessing services, and are in turn less likely to drop out of care, particularly when personal, familial, or financial crises arise.

Additionally, the EMA's model of **integrated case management** is specifically designed to help special needs populations remain adherent to combination therapies through intensive support, education, and life stabilization assistance. The addition of peer advocates and treatment advocates to the standard case management model - an approach unique to our EMA - has been especially successful in increasing the effectiveness of case management services for **multiply-diagnosed clients with severe needs**. Our FY 2007 Title I funding request includes support for **1,654** units of integrated case management service that will reach of at least **87** unduplicated high-need individuals who require these services in order to access and remain in care. Additionally, the FY 2007 Plan also includes a request for **$409,061** in support for **treatment adherence services,** most incorporated into Centers of Excellence, which are specifically designed to keep individuals in care by identifying patient barriers to medication compliance; assisting clients in communicating barriers to their primary provider; providing client education regarding HIV, substance abuse, and treatment options; and advocating for patient treatment alternatives as needed.

Promoting Parity of HIV Services: The San Francisco EMA is committed to ensuring parity of HIV services for **all** populations, and has worked since its inception to establish service systems and quality standards that facilitate access to comparable, high-quality care across our region. The EMA has consistently placed a strong emphasis on ensuring **culturally competent services** that address clients from the perspective of their own language and cultural milieus, and that are staffed by individuals who are representative of their client populations. Local services are **strategically dispersed** to ensure their accessibility within hard-hit communities and neighborhoods. The region has also consistently worked to identify and overcome **key barriers to care** for hard to reach populations, including barriers related to benefits coverage, transportation, homelessness, mental illness, substance addiction, mistrust of medical services, and HIV-related stigma. A further approach to ensuring parity involves the creation of the new Center of Excellence in the **Bayview Hunters Point / Southeast Corridor** neighborhood of San Francisco – a geographically isolated area with a disproportionate rate of low-income HIV-infected African Americans, and a shortage of quality HIV care and support programs. Establishment of a Center of Excellence in Bayview is allowing our EMA to improve health outcomes and quality of life for HIV-infected African Americans, while reaching and bringing into care significant numbers of HIV-infected individuals who do not know their HIV status and/or are not receiving care and treatment. In the same way, the **Mission Center of Excellence,**

the **Women's Center of Excellence,** and the **Native American Health Center** all provide specialized services to promote parity of service access among Latino, female, and Native American populations, respectively. The **Tenderloin Area Center of Excellence** - through a partnership with Asian & Pacific Islander Wellness Center - provides services in a number of Asian/PI languages including Cantonese, Vietnamese, and Tagalog.

Relationship and Correspondence with Healthy People 2010: Proposed FY 2007 Title I-funded services and programs of the San Francisco EMA are **fully compatible** with the goals and objectives of the US Department of Health and Human Services' *Healthy People 2010*, the nation's overarching health plan. The two broad goals of *Healthy People 2010* - to increase quality and years of healthy life and to eliminate health disparities - directly correspond to the primary goals of the San Francisco EMA's system of HIV care. At the same time, the EMA's FY 2007 Plan directly addresses several **HIV-specific goals** of *Healthy People 2010*, including Objective **#13-7**: Increase the number of HIV-positive people who know their serostatus; Objective **#13-14:** Reduce deaths from HIV infection; and Objective **#13-15:** Extend the interval of time between an initial diagnosis of HIV infection and AIDS diagnosis in order to increase years of life of an individual infected with HIV. As noted in *Healthy People 2010* in relation to this third objective, "HIV-infected persons should be identified at the earliest possible opportunity and referred to appropriate medical, social, and preventive services that may preserve their health, help them avoid opportunistic illnesses, reduce sexual and drug-use behaviors that may spread HIV, and generally extend the quality of their lives." This outcome directly mirrors the overall goals and approach of the HIV care system in the San Francisco EMA, including the new Centers of Excellence program.

Ensuring Proportional Funding for Women, Infants, Children, and Youth: Resource allocations for women, infants, children, and youth (WICY) in FY 2007 are more than proportionate to the percentage of local HIV/AIDS cases represented by these populations. As depicted in Table 1, WICY (including young people up to the age of 24) comprise **8.6%** of the total combined PLWH/A population of the San Francisco EMA through December 31, 2005 (n=**1,944**).[110] **This percentage of HIV-infected women, infants, children, and youth has historically been the lowest WICY percentage of any EMA in the United States,** reflecting the continuing devastating impact of the local HIV epidemic on MSM and IDU populations, as well as the relatively percentage of children living in the city and county of San Francisco as compared to other regions. As noted in Section 1.a.ii above, while women account for **6.8%** of persons living with AIDS in our EMA, they make up **12.6%** of all individuals receiving local CARE-funded services. Meanwhile, while infants, children, and youth under the age of 19 make up **0.6%** of the total PLWA population, they account for **2.4%** of local CARE clients. The percentage of CARE dollars spent to provide care for members of these populations is in proportion to these populations' representation in the local CARE system, reflecting both the high needs of these populations and our success in bringing them into care. The EMA works to ensure that local services are also **culturally responsive and effective** for women and young people, and these populations make up a significant share of those whom the Centers of Excellence program assists.

Minority AIDS Initiative (MAI) Funding: Minority AIDS Initiative funds have had 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. FY 2006 MAI funding in the amount of **$566,592** enabled our EMA to serve approximately **722** highly impoverished clients of color,

17% of whom were transgender people. One of the most important ways in which MAI funds ensure quality care access for communities of color is through the new Center of Excellence that has been established in the heavily Latino/Hispanic Mission district by **Mission Neighborhood Health Center.** The **Mission Center of Excellence** provides culturally competent, integrated, bilingual/bi-cultural HIV services to a total of **300** Mission community members, with an emphasis on Spanish-speaking Latino clients, in order to enhance their quality of life and promote individual and community empowerment. MIA funding helps support the cost of direct primary medical care at the organization - provided through a staff of five - as well as case management, psychiatric, and mental health services. Additionally, through an Outreach Worker funded by the State of California **Bridge Program**, the Center works within the community to identify, establish relationships with, and bring into care low-income HIV-infected individuals.

3. GRANTEE ADMINISTRATION AND ACCOUNTABILITY

a) Program Organization

The grantee agency for Ryan White CARE Act Title I 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 Title I 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 the City and County of San Francisco. The administrative unit overseeing the Title I grant is **HIV Health Services**, which is housed within the **San Francisco AIDS Office**, an organizational unit directed by **Jimmy Loyce, Jr.,** who serves as **Deputy Director for Health, AIDS Programs.** The **Director of HIV Health Services** is **Michelle Long**, who has served in this capacity for seven years. A staff of **21** individuals - each funded with different levels of Title I support - is responsible for directing, coordinating, and monitoring distribution and expenditure of Title I funds throughout the EMA. The EMA's quality management and unmet needs framework activities are coordinated in part through subcontracts with distinguished 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 CARE Act Title I and II funds. The Council's work is coordinated by **three Co-Chairs**, who at the time of this writing are **Randy Allgaier, Billie Jean Kanios,** and **Donald Soto.** 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. **Five** additional standing committees support the work of the Council: the **Community Outreach and Advocacy Committee; the Evaluation Committee; the Infrastructure and Policy Committee;** the **Membership Committee** and the **Planning Committee.** Administrative support for the work of the San Francisco HIV Services Planning Council is provided through a subcontract to **Shanti.** The current **Director** of the Planning Council is **Jack Newby.**

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

An EMA-wide Organizational Chart outlining the above relationships is included in **Attachment 1** of this application.

b) Grantee Accountability

As noted above, the San Francisco Department of Public Health (DPH) is the local government agency responsible for the administration of Title I funds. DPH oversees all public health services for the City & County of San Francisco, and contracts with community providers using processes required by local ordinances. Service solicitations clearly spell out fiscal monitoring and reporting expectations for contracted services, and all proposals must adequately describe each agency's ability to perform activities. This includes producing specific, measurable goals and objectives, and documenting the agency's prior experience in providing services to target populations. Proposal review teams include consumers, providers, and community experts, who utilize a standardized tool during the proposal review process.

In regard to **fiscal monitoring**, staff of the City and County of San Francisco Controller's Office (Controller) utilize a **two-tiered** approach. The Controller requires and reviews all **Single Audit Reports** for agencies receiving more than $500,000 in federal funding, and directly follows up on any questionable findings. In FY 2005, a total of **30** separate audit reports in accordance with OMB Circular A-133 were reviewed. Additionally, site visits are performed at least **once every three years** for all contractors that are not subject to Single Audit (under $500,000 in Federal Funding). During Fiscal Year 2005, a total of **13** separate contractor visits were performed by staff of the Controller's office. Whenever a fiscal related concern is identified during these site visits or upon review of financial audits, the contractor is required to submit a corrective action plan **within 30 to 60 days** depending on the materiality of the concern. DPH then follows up **within six months** by either performing a site visit or by requiring the contractor to submit a report summarizing the results of instituted corrective action. While no uncorrectable problems were identified during the last fiscal year, areas of identified weakness included problems with agency policies and procedures manuals; lack of full control over fixed assets; and problems in reconciliation between grant billing and general ledger. Technical assistance will continue to be provided by the Controller's office to correct these and other issues, and the City will continue to track, follow-up, and correct all negative audit results.

Meanwhile, the San Francisco EMA's **program monitoring** process is designed to ensure that contracted Title I programs: a) are effectively managed; b) meet their contract goals; c) serve their specific target populations in professional, culturally competent ways, including adhering to published standards of care; and d) are maximizing external resources to ensure that Ryan White funds are always used as the funding source of last resort. **The EMA is also increasingly concerned with ensuring that the smallest possible amount of Title I funds are left unspent and held for carry-over at the conclusion of each fiscal year.** The EMA's member counties employ a wide range of strategies to clarify provider responsibilities; track contractor performance; monitor service quality; and ensure maximized reimbursements. All contracts and programs are monitored **every year**. During the monitoring process there is an assessment of a broad range of factors, including units of service (UOS) provided; unduplicated clients (UDC)

served; achievement of process and outcome objectives; compliance with HHS Standards of Care and other requirements; and implementation of client satisfaction activities. **For FY 2005, 100% of contracted programs submitted monitoring responses to San Francisco HIV Health Services by February 28, 2006.**

Whenever a specific programmatic concern is identified, information is immediately sought from staff of the contracted agency. For example, contractors may be asked to explain why deliverables are low, why a high staff turnover rate exists, or what actions have been taken to resolve a specific consumer grievance. A recommendation to address the issue is then collaboratively developed, usually with specific deliverables and target dates for redressing the issue, such as developing a modified work plan within 30 days, or completing a process of staff training within 60 days. Providers are required to formally report on their progress in addressing such recommendations in their year-end report, as well as during the following year's monitoring process, with grantee staff following up on areas of concern throughout the year. Technical assistance is provided or facilitated for contracting agencies in areas such as staff training and orientation, adoption and replication of best practice models, collaboration with other agencies and providers, and empowerment of consumers to play a stronger advisory or leadership role within a given agency.

During Fiscal Year 2005, a total of **26** site visits to CARE Title I programs were conducted by staff of HIV Health Services, **13** of which were comprehensive monitorings for continuing programs, and **12** of which were new program site visits for newly awarded programs, including newly funded Centers of Excellence and several new outpatient mental health providers. All problems identified were relatively minor and fully correctible; examples include incomplete documentation contained in agency personnel files; lack of full participation by contract agency staff in collaborative case conferences; and, in one case, a larger than expected demand for dementia professional and para-professional patient day services. HIV Health Services staff works closely with providers to quickly resolve all such issues, and develops clear expectations between the Grantee and contractors which prevent such issues from arising in the future.

Invoices are continually reviewed to ensure that deliverables fall within **90%** of contractual objectives. If a program is having difficulty reaching its projected service units or its target number of clients, the invoice is **held for payment** while the Program Manager discusses the situation with the provider. A work plan is then developed that explains the deficiency and details the actions planned to bring the deliverables up to target by the end of the next quarter. **During the last CARE funding cycle, approximately 10% of contracts had at least one payment held due to low deliverables.** The most common reasons for underachievement included staff vacancies; start-up activities for new programs; unrealistic projections; residential vacancies due to clients' hospitalization; and seasonal variations. Common resolution of such problems include reducing contract amounts in future years; non-payment of the full contract amount; technical assistance to ensure that systems are in place to capture and report all program deliverables; and helping providers develop more realistic project measures.

c) Third Party Reimbursement

The San Francisco AIDS Office is committed to maximizing third party reimbursement across the EMA in order to ensure that Title I funds are always used as the funding source of last resort. This is not only to comply with CARE Act requirements, however; because of the extreme fiscal crisis in which our local system is embroiled, our region **must** maximize its reimbursement streams in order to ensure parity of care for PLWH/A in our region. To this end, all three jurisdictions that make up the San Francisco EMA have taken

strong steps to ensure that **all** available reimbursement streams in the region are fully utilized. This includes: a) educating providers regarding the availability of third-party reimbursement streams; b) expanding the capacity of local organizations to bill for services, including providing assistance in obtaining licensure and certification and in developing electronic billing systems; c) training agencies to conduct eligibility screening and enrollment for clients, including training to help clients manage their own benefits and eligibility; and d) providing regularly updated information on emerging developments in reimbursements, rates, and requirements. At the same time, the EMA has taken steps to verify that Title I contract agencies are fully maximizing reimbursement streams, and that rigorous protocols are being followed to ensure that Title I funds are only used **after** all other funding sources have been exhausted.

HIV/AIDS service providers who provide services covered by third party insurance and Medicaid are instructed early in the contracting process of their obligation to bill **any and all third party payer sources** prior to charging such services to the Ryan White CARE Act. All three EMA counties provide in-service and technical assistance to new and continuing contractors to help them understand their responsibility to develop and utilize a system of eligibility and financial screening whereby CARE funding is used only for eligible clients, and only when all other funding sources have been exhausted. Where needed, this can include delaying the start of a new contract until adequate systems are in place.

The generalized formula used by HIV/AIDS service providers to determine eligibility is to take each client through an **intake/registration procedure** in which standardized questions are asked pertaining to factors such as HIV status; residence; age; employment status; income; insurance; health status, and other factors that determine a client's eligibility for CARE-funded services while determining if third party insurance and Medicaid coverage is effective. Providers are then required to assist clients to obtain all benefits for which they may be eligible, including referring them to agencies that provide benefits assistance. **All HIV contracts contain highlighted language stressing that CARE funds will be used only for services that are not reimbursed by any other source of revenue,** and new contracting agencies receive training to familiarize them with other appropriate payment sources for given services and programs. Service providers are continually monitored to ensure compliance with CARE policy and guidelines pertinent to third-party reimbursement. Contracted service providers must supply a description of their screening practices for determining client eligibility for receipt of services, as well as a roster of all third-party payer sources they utilize. Written eligibility policies and procedures also must be submitted, including a detailed description of the frequency of client eligibility screening and a specification of the specific staff persons within each agency who are responsible for documenting this process. Local health department policies in all three EMA counties mandate that if a client is found eligible for coverage from a payer source other than CARE - such as Medicaid, Medicare, or private insurance - that source **must** be billed before seeking reimbursement from CARE. **In these cases, payment received is considered as payment in full, and balance-billing to CARE is not permitted.**

All CARE-funded service providers in the EMA are evaluated and given points based in part upon how well they screen for eligibility. These points are included as part of a provider's overall program monitoring assessment score. All three county health departments also conduct their own assessment of each service agency's potential for receiving third-party reimbursement for specific services, and seek explanations from specific subcontracted agencies when they do not bill or receive reimbursement for services with third-party reimbursement potential.

Technical assistance is provided where needed to ensure that agencies modify and improve their eligibility standards or attain greater competency in maximizing third-party billing procedures.

d) Administrative Assessment

The San Francisco HIV Health Services Planning Council conducts regular administrative assessments of the work of San Francisco HIV Health Services and other pertinent division of the San Francisco Department of Public Health in managing and administering local Title I funds and contracts. In the Council's last full assessment in 2004, there were **no** deficiencies noted in key Grantee contract management activities, and Planning Council members noted a high degree of competence and capacity in terms of the Department's ability to collect and report data, giving higher-than-average marks to the Grantee in areas such as effective fiscal monitoring, timely processing of invoices, and effective program monitoring. For these reasons, no plan to address key deficiencies was included in last year's FY 2006 application.

However, to address a series of ongoing communication and mutual planning issues, the Grantee began to work in 2004 with the Council to develop an **Action Plan** to address the mutually identified need for **more extensive and rapid information-sharing** between the two entities – an issue which the Council agreed was unrelated to the Grantee's competence in effectively monitoring and administering the Ryan White Title I program. This Action Plan - finalized in December 2005 - included a summary of strengths of the Grantee while offering mutually agreed-upon "threshold recommendations" for improving the thoroughness and timeliness of communication between HIV Health Services and the Planning Council.

The Action Plan was in turn followed by development of a wholly amicable **Memorandum of Understanding (MOU)** signed in February 2007 which addressed mutual expectations in regard to communication and information-sharing. The MOU included a clear delineation of the **roles and responsibilities** of both the Planning Council and the Grantee; a list of **shared responsibilities** common to both the Council and Grantee; and a series of **eight principles for effective communication** to which both parties committed themselves through the MOU. Among the most significant of these principles were: **# 1)** All parties will take responsibility for establishing and maintaining open communications; **# 2)** The Grantee will strive to have a staff member assigned to each Planning Council standing committee who will attend meetings regularly; **# 5)** Both entities will use designated liaisons and channels of communication; **# 6)** staff of both entities and Planning Council members will avoid inappropriate communication requests or channels; and **# 8)** When one entity's policies or procedures appear to be in conflict with the policies and procedures of the other entity, both parties will work together to clarify and, if appropriate, refine them. Signatories to the MOU also agreed to meet at least once each month to monitor MOU implementation and improve communication; agreed to a series of mutual expectations related to document sharing and reports; and developed a system for settling disputes or conflicts related to interpretation and implementation of the MOU. The MOU has helped significantly advance a strong working relationship between the Grantee and the Planning Council, and will serve as an ongoing framework setting clear expectations for what is expected of both entities in relation to information-sharing and open, respectful communication.

e) Use of Costs in Allocating and Dispersing HIV Service Funds

In 2003, a comprehensive **Cost of Care Analysis** was completed for the San Francisco EMA. The goal of this analysis was to determine the full range of expenses needed to deliver each CARE-funded service, in order to identify a final set of **maximum cost rates** for each category (based on per unit costs) along with **detailed service definitions** for each Title I

category. Work on the analysis included reviews of Title I and II Utilization Reports; HIV Health Services Contract Caps; relevant Medi-Cal and Medicare rates; private industry rates; and comparable rates from San Mateo and Marin Counties. The multi-agency working group responsible for the analysis recommended new reimbursement rates for **all** service categories, including services being offered for solicitation, while drafting and revising service definitions. Recommendations for maximum cost rates were submitted to the Providers Network for review and revision, and the Network in turn sponsored a series of community provider meetings to obtain additional review and comment. **The new reimbursement rates for the EMA are currently successfully used to set maximum per unit cost levels for all Title I contracts.** In 2005, HIV Health Services revisited reimbursement rates and contractor financial data in order to develop a series of initial rates of reimbursement for the EMA's new Centers of Excellence. This included projecting limited **economies of scale** based on the co-located provision of integrated services. HIV Health Services will assess CoE financial data over the coming years to determine whether the Centers will lead to altered reimbursement rates for some CoE services.

4. IMPACT OF TITLE I FUNDING: ACCESS TO CARE SERVICES AND FUNDING MECHANISMS

a) The EMA's Established Continuum of HIV/AIDS and Access to Care

Maintaining a Comprehensive 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 and systems 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 crisis, our region responded by developing a comprehensive network of services centered around state-of-the art medical programs developed at San Francisco General Hospital. That early system utilized **case management** to link individuals to medical and supportive services, and became known as the **"San Francisco Model of Care"** - a model that had a lasting impact on the organization of HIV services in the US. The model was codified in Ryan White CARE Act legislation, exemplified by HRSA's emphasis on the development of "comprehensive, seamless systems of care" - a terminology that mirrors San Francisco's early service approach.

Over the past decade and a half, our EMA has continued to evolve and grow its system of care to respond to changes in the epidemic and its affected populations, while incorporating new treatment developments. With the introduction of combination drug therapies in the early 1990s, the San Francisco EMA modified its approach to ensure access to the new medications, while incorporating **peer-based treatment adherence strategies** to help patients remain on complex regimens. In the mid-1990s, as the epidemic had an increasing effect on individuals disenfranchised from health and social service systems, San Francisco developed the **Integrated Services Program,** an intensive, multidisciplinary approach to care in which HIV services were merged, coordinated, and linked in order to stabilize and retain the hardest-to-reach and most severely affected individuals in care. Over the past two years, this approach has evolved further, culminating in a dramatic intensification of the integrated services model in the form of the EMA's seven new **Centers of Excellence** - programs that are offering a wholly original approach to stabilizing the lives of multiply diagnosed and severe need populations through neighborhood-based, multi-service centers directly geared 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, four consecutive years of Title I funding reductions

have presented our EMA with the most serious threat we have yet faced to the survival and continued evolution of what began as the San Francisco Model of Care. The growing crisis threatens our EMA's ability to continue serving all persons with HIV, and sets the stage for an even greater crisis in the future as more individuals with more complex needs begin receiving treatment for HIV. The San Francisco EMA has continually 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, our ability to continue providing that level of care - despite our best efforts to implement more cost-effective service models - is seriously threatened.

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 **case management** providing individualized coordination and entry points to the full range of social and supportive services. In addition to 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 CARE-funded providers throughout the EMA are trained to refer persons with HIV to **any** primary care service site in the region.

In addition to primary 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 to help persons living with HIV (PLWH) cope with more complex medical needs - services such as home health care and adult day health care - while helping facilitate access to medical care through services such as transportation and childcare. A range of ancillary services helps clients better manage the circumstances of their lives in order to consistently access treatment - services such as benefits counseling, money management support, and legal and immigration assistance. Inpatient care is provided in a range of supportive settings, most funded through non-Title I sources. A comprehensive matrix of HIV prevention, counseling, testing, early intervention, and care linkage services are supported through non-Title I funding streams, many of them directly linked to the new Centers of Excellence system.

Helping Individuals Access and Remain in Care: The primary challenge of Title I-funded agencies in the current environment is to deliver services that stabilize peoples' lives so that they can consistently access care, while striving to provide comprehensive, quality care for those whose lives remain chaotic. An increasingly large proportion of those affected by HIV in our region have co-morbidities such as homelessness, poverty, mental illness, substance addiction and/or a range of additional health and life complications. The integrated services program originally developed in San Francisco proved to be highly successful in bringing such hard-to-reach clients into care and in 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 and terminated** as

a result of Title I funding cuts in our EMA from FY 2003 through FY 2006 - 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. A roving team in San Francisco provides care, triage, and referrals to individuals who are on the street or unable to go to a primary care clinic. 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 needed to access services on a long-term basis.

Additional Title I-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 to ensure entry and retention in care is by providing **culturally competent** services that are comfortable and accessible to clients, and that are provided in a manner that allows 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. Today, community of color organizations provide culturally-centered care for a wide range of populations, particularly in the city's hard hit African American, Latino, and Asian communities, providing uniquely tailored services such as substance abuse treatment for monolingual HIV-positive Spanish speaking clients. Agencies such as Ark of Refuge, 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 Title I contracts to provide care to persons of color in our region.

At the same time, San Francisco embraces a definition of "culture" that includes not only ethnicity, but a wide range of sexualities, gender identities, family groupings, and lifestyles, all of which have their own cultural systems and networks requiring competent, respectful, and tailored interventions to help them enter and remain in HIV care. Local HIV providers share an unparalleled understanding of and sensitivity to the needs of MSM individuals and communities, and are able to provide care that brings and retains the vast majority of these populations into testing and treatment. At the same time, women-specific providers such as A Woman's Place, Iris Center, Lyon-Martin Women's Health Services, and the UCSF Women's Specialty Clinic; youth providers such as Larkin Street Youth Services; and transgender providers such as the Transgender Clinic at Tom Waddell Health Center and the Tenderloin AIDS Resource Center all facilitate care to our region's broad spectrum of diverse cultural groups.

Reducing Disparities and Improving Access to Care: The San Francisco EMA's new Centers of Excellence network forges a new type of "safety net" for severe need and special populations, one that encompassing a range of population and neighborhood emphases and that is in turn expected to make a **major** contribution to our EMA's goal of reducing disparities and improving access to care for hard-hit and underserved communities. The **Mission Center of Excellence, Native American Center of Excellence,** and **Southeast Partnership for Health,** for example, provide culturally competent services for **three** key hard-hit populations of color in our region: Latinos/Hispanics, Native Americans, and African Americans, respectively. The **Women's Center of Excellence** provides a unique range of services specifically tailored to the needs of HIV-positive women, while the **Tenderloin AIDS Resource 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. Meanwhile, the services of the **Forensic AIDS Project** provide 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. As mentioned above, all CoEs also incorporate prevention with positives interventions (PWP) into their care regimens - using standards developed by HIV Health Services - and are fully linked to the regional HIV counseling and testing network. For example, the **Women's Centers of Excellence** 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 an on-site Prevention Coordination; and ongoing risk-reduction groups and other services, such as 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 12).

Figure 12. Chart of San Francisco EMA Centers of Excellence (CoEs)

Name of CoE	Lead Agency	Location(s)	Target Populations	Title I Funded?
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, 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	√
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	√

Name of CoE	Lead Agency	Location(s)	Target Populations	Title I Funded?
Tenderloin AIDS Resource Center of Excellence	Tenderloin AIDS Resource Center	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 new CoE program, Minority AIDS Initiative funds have had 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 (FY) 2006, MAI funds have continued to be used to support outreach, treatment adherence, and case management programs specifically targeted to those populations most underserved by existing programs, including women of color, Asian & Pacific Islanders, and African Americans. Meanwhile, treatment adherence services target transgender women of color, Native Americans, 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. Each program has a culturally appropriate modality to help clients learn about, access, and adhere to medical care, such as a treatment support group for Native Americans that also functions as a beading class. MAI-funded transitional case managers have been especially successful at connecting **incarcerated PLWH 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.

The EMA's Case Management System: Ensuring Core Service Access: The San Francisco EMA has historically utilized case management services as the linchpin of its approach to ensuring seamless, comprehensive HIV care. As noted above, San Francisco was the first city to develop the approach of applying case management to the HIV/AIDS epidemic, using it as a **hub** of service access for desperately ill people struggling to meet a range of health and psychosocial needs simultaneously. Since then, San Francisco has continually refined and enhanced its case management model to respond to the evolution of HIV disease into a condition more akin to **chronic disease**, while adapting it to better meet the needs of growing severe need and multiply diagnosed populations.

For FY 2007, the San Francisco EMA allocates Title I funds to support **three** distinct categories of case management. **Standard case management** services provide one-on-one support designed to link and coordinate assistance from multiple agencies and caregivers providing psychosocial, medical, and practical support services, in order to ensure that clients attain the highest level of independence and quality of care consistent with their functional capacity and care preferences. **Residential case management** offers the same form of support, but within the setting of residential and housing programs supported through Ryan White Title I funding, with a particular emphasis on homeless populations and on multiply diagnosed

individuals who are in residential facilities as a result of substance abuse or mental health issues. **Integrated case management** is a form of case management that combines one-on-one case management services with peer advocacy and treatment advocacy in order to help the most complex and severely impacted clients address a combination of life factors in order to enter care and remain compliant with medications. Of the **$3,726,688** in requested FY 2007 Title I case management funds, **66.0%** supports standard case management; **31.4%** supports residential case management; and **2.6%** supports integrated case management for a very focused population of mainly Spanish-speaking severe need clients. Both the Planning Council and Grantee have worked to develop systems to ensure that each Title I-eligible consumer utilizes **one** primary case manager, while Standards of Care for case management services are in place throughout the EMA, accompanied by ongoing provider training to ensure adherence to these standards. Throughout the EMA, the overall goal of case management services is to preserve and maintain people in care by stabilizing the circumstances of their lives and facilitating access to needed health and psychosocial services.

b) Report on the Availability of Other Public Funding –

See **Table 4** in Attachment 1.

c) Coordination of Services and Funding Streams

Coordination with Other CARE Act Programs: 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 CARE funds for services that are not adequately funded through other reimbursement streams in order to ensure that Title I 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 Title III and Title IV programs, SPNS, and Dental Reimbursement programs. The San Francisco Planning Council also serves as the Title II Consortium for its region, and plans Title I and II services **concurrently,** to ensure that there is no duplication of services. The Planning Council also works with other 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. During the FY 2007 prioritization and allocation process, the Planning Council received a full report on **HOPWA** and **HUD** services in the EMA, a report that specifically identified housing gaps in relation to Title I funding.

Coordination with Other Federal and State Resources: The San Francisco HIV Health Services Planning Council and the SF Department of Public Health work together to ensure that CARE Title I funds are fully coordinated with all applicable funding streams in our region, and that Title I funds are **never** utilized unless there is no other source of funding available. As with the Ryan White streams listed above, the Planning Council receives annual service category summaries that include a detailed listing of all non-Ryan White funding streams available to support each category, including sources such as ADAP, Medicaid and Medicare support, public entitlement programs, private insurance and HMO support, Veterans Administration programs, city and county funds, HOPWA and SAMHSA grants, and state mental health funds. The Grantee also works to ensure that services are coordinated to maximize the number and accessibility of services, while seeking every possible alternate source of funding apart from Title I to support HIV care. In the face of dramatic Title I cutbacks in 2005, the AIDS Office worked with the San Francisco Mayor and Board of Supervisors to secure one-time, general fund

support to help downscale and shut down programs in a gradual, time-phased manner - an approach that helped minimize the already-dramatic impact on clients' lives.

At the same time, our system has for many years been approaching what has now become a critical stress point - a point at which all available funding streams are already maximized, and at which additional funding cuts will inevitably cripple the system and lead to a lack of access to care for hundreds of HIV-infected individuals. Last year, for example, Title I funding reductions forced Continuum to close its popular day care program in San Francisco - the only program of its kind in the city. Even relatively small cuts in CARE funding for specific programs - such as the Shanti van service - have resulted in the elimination of these programs when agencies could not locate funding to compensate for these reductions. In addition, new CDC HIV testing guidelines announced as this application was being finalized calling for so-called "opt-out" HIV testing in most health settings could potentially swamp the system with new cases at a time when no additional federal funding is anticipated.[111]

Some of the most significant non-Ryan White funding streams which affect the allocation of Title I resources and determine our region's overall level of care are the following:

- **Medi-Cal** - As described in Section 1.b.iii. above, California's statewide Medicaid program - is the single most important source of local funding for direct HIV care. Continuing to maximize Medi-Cal reimbursements remains a critical priority, and the Planning Council has spent significant time developing collaborative approaches to ensure that all Medi-Cal eligible services are billed appropriately by providers, including establishing tighter restrictions and expanded reporting standards for contracted agencies, and expanding training in Medi-Cal eligibility and registration for benefits counselors and other staff.
- Veterans in the EMA are able to access care at two **Veterans Administration (VA)** clinics in the EMA: the Infectious Diseases Clinic at the San Francisco VA Medical Center, offering primary medical care to PLWH along with access to clinical trials and research, and the Palo Alto VA Center located just outside the EMA, with a satellite clinic in San Mateo County which is co-located with a public Title I clinic.
- **Housing Opportunities for Persons With AIDS (HOPWA)** services are coordinated through the HOPWA Loan Committee, which includes two Planning Council representatives. The Grantee also works closely with the San Francisco Redevelopment Agency, which administers HOPWA funds. CARE funds allocated for housing and HOPWA funds are fully utilized due to the local housing crisis. CARE-funded subsidy providers are also fully coordinated with **Section 8**. Section 8 is heavily over-subscribed in San Francisco; there are currently over **30,000** families on the waiting list, which is closed to new applicants, and only about **1,000** families per year are housed from this list.
- Other state and local social services programs, such as **General Assistance** and **vocational rehabilitation programs**, are used by PLWH in the EMA. General Assistance provides a very small amount of money per month, less than the average SRO hotel rent. Vocational services including counseling, training, and job placement are provided directly to PLWH who wish to enter or re-enter the workplace.
- **Substance abuse services** are supported through a combination of federal, state, local, and private funds, with each county cobbling resources together to develop its own local system. The passage of California Proposition 36, requiring drug treatment rather than incarceration for many persons convicted of drug-related offenses, has increased funds available for substance abuse treatment, but it has also increased the population requiring treatment. California also receives HIV set-aside funds from **SAMHSA**, which are primarily used to

provide HIV counseling and testing within substance abuse treatment programs. While state and federal funds supplement substance abuse treatment services in the EMA, these resources are woefully inadequate to the need. In San Francisco, there are approximately **300** individuals on a waitlist for methadone at any one time. San Francisco General Hospital, which receives both Title I and SAMHSA funds, has one of the longest wait lists for methadone, and **over half** the individuals on the list are HIV-positive.

5. PLANNING COUNCIL MANDATED ROLES & RESPONSIBILITIES

a) Letter of Assurance from Planning Council Chair

See **Planning Council Letter** in Attachment 2

b) Description of Priority Setting and Allocation Process

Overview of the Prioritization and Allocation Process: Since its founding, the San Francisco HIV Health Services Planning Council has made the widest possible range of quantitative and qualitative data available to assist Planning Council members in assessing needs, measuring progress, identifying gaps, prioritizing services, and allocating resources. The Planning Council has also consistently incorporated **broad-based consumer participation** to arrive at a balanced and effective set of goals and objectives to improve the region's comprehensive system of care. **These activities took on greater urgency in the process of determining FY 2007 priorities and allocations, as the EMA has struggled to cope with four successive years of dramatic cuts in Title I funding, representing a reduction of 17% in the EMA's Title I funding over the past four fiscal years alone.** The need to balance reduced funding with the Title I requirement to provide an effective, comprehensive system of care for a continually expanding HIV-positive population compelled the Planning Council to make some extremely difficult decisions this year – decisions that will inevitably impact the quality and scope of HIV services in our region.

As in previous years, the San Francisco EMA employed a **multi-phased process** for FY 2007 priority-setting and allocation. This process began early in the year with planning meetings of the Council's Steering Committee, and meetings of the Planning Committee to assess preliminary data and develop a set of initial prioritization recommendations. Because of the significance of this year's funding decisions, the Council sponsored a **two-day Prioritization and Allocation Summit** in San Francisco on August 24 and 26, 2006. Key activities for the Summit's first day included: a) a review of the Council's conflict of interest policy; b) a discussion of Summit goals; c) a review of the new 2006-2009 Comprehensive Plan; d) a detailed presentation of trends and analysis factors within the EMA; e) a series of small group discussion to discuss the trends and analysis data, and report-backs on small group findings and recommendations; f) presentation of Planning Committee recommendations for priority-setting, and a subsequent discussion and vote on priorities; and g) the beginning of a group discussion on the resource allocation process. Day two of the Summit was almost exclusively focused on allocations, and included a detailed presentation on the context of Title I and non-Title I funding in the EMA; extended discussions and voting on funding allocations decisions; and development of emergency funding scenarios to help cope with potential decreases in Title I funding.

The planning process reflected the diverse conditions within our EMA, as well as our commitment to maximizing Title I resources to meet urgent needs and to complement other Ryan White and non-Ryan White funds, ensuring that CARE Act resources are used as the funding source of last resort. The Planning Council placed a strong focus on the continued consideration and prioritization of HRSA's identified **core categories** throughout the prioritization and allocations process, weighing priority rankings and funding amounts particularly in terms of

unmet needs for HIV care in the EMA, and the diminished resources available to stabilize life circumstances for complex and underserved populations. **These considerations directly resulted in a total funding increase this year of 21% across the five HRSA core categories over FY 2006 funding levels.**

Persons living with HIV and AIDS (PLWHs) were integrally involved in all phases of the FY 2007 priority-setting and allocation process. PLWHs attended the **three** community fora sponsored by the Planning Council in the spring of 2006, including a **Latino Community Forum** in May; forum for PLWH/A 50 years of age and over in June; and a **General Community Forum** in June that was attended by nearly **60** consumers who offered their input and opinions regarding needs and gaps in the HIV service system. Self-identified persons living with HIV currently make up **57%** of the total membership of the San Francisco HIV Health Services Planning Council (**21** HIV-positive members), while non-aligned consumers make up **36%** of the total Council membership (**13** non-aligned consumer members), and all HIV-positive Council members played a leadership role in the prioritization and allocation process. **Two** of the Council's Co-Chairs are persons living with HIV, and at least one of the co-chairs of each committee is a person living with HIV.

The Council also relied heavily on its **2005 Comprehensive HIV/AIDS Health Services Needs Assessment**, which included in-depth client surveys completed by **607** persons living with HIV and/or AIDS in all three counties; a series of **11** population-specific focus groups; and a provider survey completed by **21** of the region's HIV/AIDS service organizations.[112] The Assessment deliberately over-sampled members of the **African American** community in order to better identify needs among members of this hard-hit and historically underserved population. In order to expand our understanding of out-of-care populations, fully **13%** of all those participating in the Assessment were HIV-positive individuals who were currently **not in care.** Of these, **68%** had **never** been in care; **32%** had not been in care for over a year; and **4%** had never seen a doctor since learning of their HIV status. Of those individuals who had never seen a doctor or had not seen one for more than a year, fully **60%** were African American; **23%** were female; **41%** were heterosexual; and **all** were below 150% of Federal Poverty Level. The Needs Assessment was instrumental in guiding FY 2007 prioritization and funding allocation decisions, and ensured that the needs and perspectives of persons living with HIV/AIDS – including those not in care – were continually incorporated into the prioritization and allocation process.

Consideration of Current Data Sources: As in past years, the Planning Council received a broad range of data - including unmet needs data - to assist in prioritizing FY 2007 services and allocating resources, with an emphasis on HRSA-identified **core services**. Data presented, reviewed, discussed, and incorporated by the Council in its decision-making this year included:

- A **detailed analysis of each priority service category** funded and not funded by the Council in FY 2006 by County, including service definitions; budgeted and actually funded service category amounts; populations served; key points of entry; utilization reviews; a listing of other funding sources available to support care in each category; issues and trends; and possible impacts of cuts in each service category;
- A **comprehensive, updated HIV/AIDS Epidemiology Report** prepared by the San Francisco AIDS Office detailing current PLWA / PLWH populations, and discussing current trends in the epidemic;
- A detailed analysis of **client-level data** reported through the Reggie system, including information on the demographic characteristics and changing health status of CARE-

supported clients; information on the financial and insurance status of CARE clients; and service utilization data related to all Title I services;

- An update on **quality management** activities within the EMA, including a discussion of data findings as they related to key Title I quality of care issues;
- An updated summary of the **2005 Comprehensive HIV/AIDS Health Services Needs Assessment,** including a summary of key findings as they related to issues such as substance use, out of care populations, severe need populations, and service utilization;
- A summary estimate of **unmet need** among PLWA and PLWH in the San Francisco EMA utilizing HRSA's unmet needs framework, including a detailed breakdown of unmet need by population, and an analysis of EMA neighborhoods in which unmet need is most prevalent;
- A summary of the findings of the **three community fora** sponsored by the Planning Council in May and June 2006 designed to gather direct client input for the prioritization and allocations process;
- A detailed presentation on **other funding streams** in the EMA, including a summary of Title I MAI, Title II, Title III, Title IV, San Francisco Department of Health, and other funding sources;
- A review of goals and objectives from the **2006-2009 Comprehensive HIV Health Services Plan,** along with updated progress reports for each goal, objective, and action step;
- A presentation by HIV Health Services on the **Centers of Excellence** program, including initial accomplishments and detailed information on populations served;
- A comprehensive presentation on the issue of **HIV housing** in San Francisco, including presentations on facility-based care, HOPWA, and HUD resources; and
- Consensus input to the Planning Council from a group of **46** community-based, non-profit **HIV service agencies** in the San Francisco EMA represented by the **San Francisco HIV/AIDS Providers Network.**

All of these data were utilized by the Council in part to ensure that proposed FY 2007 allocations increased access to HRSA-identified **core services**. The final FY 2007 Implementation Plan resulted in a combined allocation for HRSA core services that represented **60.8%** of the EMA's total direct service funding request (see Table 5 in Attachment 1). At the same time, **six** HRSA core categories were included in the **top ten** service priorities for the San Francisco EMA, and **five of the top six** EMA service priorities were HRSA core categories. This includes **AIDS Pharmaceutical Assistance**, which is the **# 2 priority** of the Planning Council this year. As noted above, because the State of California has long maintained one of the strongest and most comprehensive AIDS Drug Assistance Programs (ADAPs) in the U.S., and because of our EMA's success in reaching Medi-Cal eligible populations and enrolling them in care, the San Francisco EMA does **not** utilize Title I funds to support AIDS Pharmaceutical Assistance, despite the fact that the service is highly prioritized by the Planning Council.

Utilization of HIV/AIDS Epidemiology Data: The Council fully incorporated **changes and trends in HIV/AIDS epidemiology data** in this year's priority-setting and allocation process. As noted above, the Council reviewed a comprehensive, updated HIV/AIDS Epidemiology Report prepared by the San Francisco AIDS Office detailing current PLWA / PLWH populations, and discussing current trends in the epidemic, as well as a summary estimate of **unmet need** among PLWA and PLWH in the San Francisco EMA utilizing HRSA's unmet needs framework, including a detailed breakdown of unmet need by population, and an analysis of EMA neighborhoods in which unmet need is most prevalent. The consideration of HIV/AIDS epidemiology data directly influenced key prioritization and allocation decisions by the Council.

For example, the Council affirmed its commitment to the Centers of Excellence program in part as a strategy for addressing growing HIV infection rates among **young women of color** and **MSM of color**. The Council also discussed the growing proportion of PLWH/A **over 50 years of age** in the EMA, identifying the need for more information to meet the needs of these groups, and to integrate this care into emerging approaches for HIV-related geriatric services.

Applying Cost Data to Title I Service Allocation: The Planning Council consistently incorporated **cost data** into its considerations, drawing from detailed reports prepared by HIV Health Services for **each** funded and unfunded Title I service category. These included a full utilization review for each service category listing total dollar amounts, unduplicated clients, and cost per unit of service; a listing of **all** non-Title I funding sources available for each category; a description of issues and trends affecting the categories; and a description of possible impacts of further cuts. These data were accompanied by cost estimates related to care for **special populations.** At the same time, the Council received a detailed presentation on **other funding streams** in the EMA, including a summary of Title I MAI, Title II, Title III, Title IV, San Francisco Department of Health, and other funding sources such as Medicare, private insurance funding, and funds provided through the US Substance Abuse and Mental Health Services Administration (SAMHSA). The funding streams presentation also included information on the history, current funding and programmatic levels, and challenges and gaps related to each funding source. All cost-related data directly influenced both prioritization and funding decisions made by the Council, including an increased commitment to the Centers of Excellence program as a strategy for creating greater cost-effectiveness in serving severe need populations, and a continuing emphasis on treatment adherence support as a strategy for avoiding later burdens on the system related to emergency hospitalization and home-based care.

Planning for Potential Fluctuations in the Title I Award: As in previous years, the Planning Council developed a detailed **contingency plan** offering a blueprint for how the Council would respond to potential increases or decreases in FY 2007 Title I funding. This Council agreed that increased funds would be distributed proportionally among the highest ranked service categories, including all HRSA core categories. In the event of funding reductions, the Council made the following decisions:

- In the event of a funding reduction of **up to 5%** of current FY 2006 Title I funding levels, all service categories will be reduced proportionally;
- In the event of a reduction of **between 5% and 10%** of current funding levels, non-HRSA core services will receive an automatic 10% cut; services receiving less than $100,000 per year will be held harmless; and the remainder of cuts will be distributed proportionally among HRSA core services; and
- In the event of what would be a disastrous **10% - 15%** cut, there will be no hold harmless; there will be an automatic reduction of 15% in all non-core services; and remaining reductions will be absorbed by HRSA core services proportionally.

c) Compatibility with the Statewide Coordinated Statement of Need

The proposed FY 2007 San Francisco EMA Title I Plan is fully compatible with the findings and recommendations of the most recent California Statewide Coordinated Statement of Need (SCSN) published in January 2006.[113] The San Francisco EMA's goals and activities both mirror and complement the goals of the SCSN, and create a framework for cooperative progress in HIV/AIDS service delivery for EMAs throughout the state. A description of some of the 2006 California SCSN's key overarching goals - and the complementary goals of the San Francisco EMA - is provided below:

- **To provide all persons living with HIV in California with the services necessary to sustain and support their health and quality of life, regardless of income or ability to pay, and across all stages of illness, by maintaining and enhancing California's community-based system of HIV/AIDS care:** Our FY 2007 Plan directs Title I funds to services that are necessary to support and sustain quality of life, and that meet the needs of those **least** able to pay for services, in order to increase access and eliminate disparities, and ensure a seamless, comprehensive system of care for all EMA residents.
- **To ensure that HIV/AIDS services in California are delivered by experienced, competent, and fully trained providers who are knowledgeable about and responsive to their communities, and who understand and represent, to the extent possible, the cultural, linguistic, and community backgrounds of the clients they serve:** Providers throughout the San Francisco EMA are committed to providing culturally appropriate services to all clients, a commitment that has grown out of their longstanding experience in serving this diverse and culturally mixed region. All three counties of the EMA track the ethnic composition of Title I contractor staff, while continually ensuring that services comply with published standards of care and are delivered by trained professionals in a culturally and linguistically competent manner.
- **To increase evaluation efforts and approaches that allow us to better assess the quality of care provided to PLWH, and to better document the outcomes and impacts of HIV care and services on the lives and health status of PLWH:** The San Francisco EMA is consistently developing new and refined approaches to gathering information and data regarding care quality and outcomes, including implementing expanded quality management activities within Centers of Excellence; refining computer-based systems that facilitate detailed and timely contractor reporting; and ensuring increased accuracy of annual unmet needs estimates.

d) Planning Council Assessment of the Administrative Mechanism

As noted in Section 3.i.d above, the San Francisco HIV Health Services Planning Council conducts regular administrative assessments of the work of San Francisco HIV Health Services and other pertinent divisions of the San Francisco Department of Public Health in managing and administering local Title I funds and contracts. While full-scale assessments are not currently conducted on an annual basis, the Council continually monitors the work of the Grantee in administering Title I funds, and provides input where needed to address specific issues. The Grantee provides quarterly updates on the contract development process, quality management activities, and conditions of award met to the full Council. During the last large-scale administrative assessment in 2004, the HIV Health Services Planning Council distributed a series of surveys to members of the HIV Health Services Planning Council and to CARE Act-funded service providers, while supplying a self-assessment questionnaire to the Grantee agency.

At the present time, the Planning Council is actively involved in implementing a recently developed **Memorandum of Understanding (MOU)** signed in February 2007 with the Grantee, designed to address mutual expectations in regard to communication and information-sharing identified through the 2004 assessment. As noted in Section 3.i.d, the MOU includes a clear delineation of the roles and responsibilities of both the Planning Council and the Grantee; a list of shared responsibilities common to both the Council and Grantee; and a series of **eight** principles for effective communication to which both parties have committed themselves. The Planning Council and the Grantee have also agreed to meet on at least **a monthly** basis throughout FY 2007 to monitor MOU implementation and improve communications. The MOU

has helped significantly advance a strong working relationship between the Grantee and the Planning Council, and will serve as an ongoing framework setting clear expectations for what is expected of both entities in relation to information-sharing and open, respectful communication.

6. BUDGET AND MAINTENANCE OF EFFORT

See Budget Sections and Maintenance of Effort documentation in Attachment 2

7. QUALITY MANAGEMENT & UNMET NEED

7.I) Quality Management

a) Description of Quality Management Program

Purposes and Goals of the Quality Management Program: The San Francisco EMA operates a dynamic, multi-tiered quality management (QM) program designed to ensure the highest quality of care, outcomes, and cost-effective services for local consumers that **greatly exceeds** the minimum HAB quality management expectations outlined in the Title I guidance. The basic goals of the program are threefold: 1) to improve client service practices; 2) to ensure continuous, accurate electronic data collection and analysis of CARE-funded services in the SF EMA through the Reggie database for Title I- funded services; and 3) to reliably track progress toward established markers and milestones. In order to achieve these results, the program incorporates a broad range of key quality management components, including:

- **Standards of Care and Best Practices for HIV Service Delivery:** Standards of Care have been developed for **all** service categories, and two new documents to guide care quality - ***Best Practices for Communities of Color*** and ***Best Practices for Transgender Individuals*** (the latter funded through a Title III capacity-building grants) are in final review stages. In accordance with PHS guidelines, both the Standards of Care and Best Practices documents are designed to facilitate effective and culturally relevant care throughout our service continuum.
- **HIV Provider Training Program:** Our comprehensive training offers both standards of care orientation and specialized workshop on subjects such as HIV Treatment Updates, Multidisciplinary Case Conferencing, and Transgender Cultural Competency. Beginning in May 2006, the EMA began a new **CBO Capacity Building Training Series** funded through the US Office of Minority Health designed specifically for community of color agencies, covering topics such as Supervision and Management Best Practices. Our provider training programs allow us to focus on skills-building in direct client care and on infrastructure issues related to sustaining the viability of our provider agencies in the face of expanding populations and declining resources
- **Technical Assistance and Program Evaluation:** Technical assistance is an ongoing element of our QM program. During the past year, our TA efforts have focused on the newly-formed Centers of Excellence, which establish an integrated approach to core services in the EMA. Assistance has been provided to the CoEs in areas such as the establishment of collaborative partnerships; effective management of client records; and multidisciplinary case conferencing. We have also embarked on a formative research evaluation on the development and client efficacy of the Southeast Partnership for Health CoE, which serves African Americans residing in the Bayview Hunters Point community in Southeast San Francisco.
- **Data Management Standards and Compliance:** The central activity for this component involves assistance with data compliance and technical support for the Reggie system, which tracks data and quality management performance indicators for clients receiving HIV

services in San Francisco. Data management reports are provided by the Data Systems Coordinator on a monthly basis to ensure that all subcontractors are meeting client-level and service data compliance requirements. Agencies with incomplete or missing client and/or service level data are identified and correction plans developed. As necessary, the HIV Health Services Data Systems Coordinator deploys data management staff to agency sites to facilitate data entry and prevent a backlog of information in the shared client database.

- **Health Outcomes and Indicators for Core Services:** The development and tracking of measurable health outcomes as a result of services rendered by CARE providers in the SF EMA is an ongoing focus of our QM effort. As part of this effort, agencies may receive on-site technical assistance to help them understand and track outcome measures, or to help them implement internal quality management plans which are in compliance with HRSA's quality management standards for CARE-funded agencies. Tracking health outcomes also serves as a key mechanism for monitoring care trends and needs and subsequently planning for HIV services that are responsive to current client needs.

Quality Management Oversight: The Director of HIV Health Services for the San Francisco Department of Public Health AIDS Office, Michelle Long, oversees Title I-related quality management activities for the San Francisco EMA. Under her supervision, quality management program components are developed and implemented by the Quality Management Program Coordination Consultant who works in collaboration with the HIV Health Services Data Systems Coordinator and other HIV Health Services staff as necessary to develop and implement new or enhanced quality management programs. Additional consultants support the QM program through the provision of services such as training, technical assistance, program and training evaluation, and administrative support. The EMA's core annual Quality Management contract totals $250,000, although additional staff and consultants provide additional support in developing and implementing specific aspects of the QM program.

Internal Quality Processes: The Quality Management Program Consultant, who contracts directly with the City of San Francisco, is monitored annually by HIV Health Services to ensure that contract deliverables for the EMA's Quality Management Program are being met satisfactorily. Annual year-end progress reports are also submitted to monitor program achievements. The Quality Management Program Consultant works closely with HIV Health Services to ensure that the quality management activities are formulated in a manner consistent with HRSA requirements. The Quality Management Program Consultant is responsible for monitoring the timely completion of duties by all project subconsultants under her supervision on a monthly basis.

The Director of HIV Health Services provides ongoing updates and information regarding quality management activities to the San Francisco HIV Health Services Planning Council. Additionally, the Quality Management Program Consultant and the HIV Health Services Data Systems Coordinator both provide formal progress reports to the Health Services Planning Council on the status of the quality management program and the client-level data system. The Planning Council is notified of quality management training schedule and is invited to attend workshops. Evaluations are also completed for each training and an annual training progress report is submitted to HIV Health Services to monitor and improve the training component.

Continually monitoring contractor adherence to PHS guidelines and standards of care comprises another key aspect of internal quality monitoring. As noted above, Standards of Care have been developed for each of the CARE service categories in order to establish **minimum expectations** for service delivery within the EMA, including standards for Benefits

Counseling; Case Management; Complementary Therapies; Dental Services; Food Services; Home Health Care (Residential and Home-Based); Housing Services; Mental Health; Money Management; Peer Advocacy; Primary Care; Substance Abuse; and Treatment Advocacy. Monitoring of subcontractor compliance with these standards of care has been fully incorporated into the annual monitoring process coordinated by HIV Health Services, and monitoring tools have been developed for each of these standards and included as part of the monitoring site visit packets for CARE-funded agencies in the EMA.

Specific Indicators Being Monitored: The intent of Quality Indicators is to identify markers for tracking measurable health outcomes as a result of services rendered by providers. Indicators currently being tracked by HIV Health Services for primary care and case management are as follows:

- **Primary Care: a) 75%** of clients will show improved or maintained CD4 counts over time (6 month period); **b) 75%** of clients will show improved or maintained viral loads over time (6 month period); and **c) 75%** of clients who choose to go on HAART will be prescribed and remain on HAART over time (6 month period);
- **Case Management: 85%** of clients will maintain their primary care;

In order to track these indicators, HIV Health Services establishes benchmarks with each agency at the beginning of the contract period, and provides training and technical assistance as needed to ensure that agencies understand and are able to meet Reggie reporting requirements. HIV Health Services aggregates agency data on an ongoing basis to track progress toward stated indicators, and immediately discusses variations with agencies when they are identified, collaboratively developing remedial responses to ensure adherence to quality standards.

Overall EMA Data Collection Strategy: Client-level data is collected and entered by providers into **Reggie**, the system-wide shared client database to which all San Francisco CARE agencies are now linked. The Reggie system collects a range of client-level data, from basic demographic information to medical data fields depending on each provider agency's service modality. The data compliance standard is **95% completion for all required data fields**. Since August 2004, all Title I contractors are required to provide client-level data as a condition of award, and as an ongoing pre-condition for receipt of payment for services delivered. In addition, provider invoice data (UOS and UDC) **must** match the Reggie service line item data.

A comprehensive set of outcome indicators has now been developed for the Centers of Excellence; agency training and orientation has taken place; and initial data collection and analysis has begun. CoE outcome indicators include a total of **eight** separate primary medical care outcomes related to factors such as ARV therapy management and adherence; HIV staging and monitoring; PCP prophylaxis; and hepatitis and STI screening. Individual outcome indicators have also been established for all ancillary services provided within the Centers, including an outcome related to prevention with positives services. HIV Health Services has also established **two Center-wide objectives,** both directly related to the goal of using the CoEs to retain in care and improve the quality of life for severe need populations: a) Not more than **10%** of unduplicated clients will have been lost to follow-up by the end of a given contract period; and b) At least **90%** of unduplicated clients not lost to follow-up will self-report an improvement in quality of life by the end of each contract period. Unfortunately, because the quality management system for the CoEs has been implemented only recently, no systematic outcome findings are available for this application related to the Centers. Initial compliance with Reggie data requirements has been extremely high, however, and we anticipate being able to report significant new findings in early 2007 which will both describe the initial impact of the Centers

and suggest the extent to which they are involving and retaining new HIV-infected populations in the regional system of care. Preliminary findings from the Mission Center of Excellence, for example, demonstrate an increase in the use of medical case management services of **63%** in the first year of the program, and an increase of **333%** of client referrals to mental health providers to HIV-positive consumers. Even more impressively, of the HIV-infected consumers currently being served by the Southeast Partnership for Health, **34%** report not receiving any form of medical care for **at least three months or more** prior to entering the CoE, and **43%** of clients report that they had not received case management services within the past three months or more.

Improvements in Service Quality and Delivery: The application of quality management data has consistently led to significant enhancement and refinement of services in the San Francisco EMA. Careful analysis of QM data, for example, played a key role in helping the Planning Council make initial funding allocations for the EMA's new Centers of Excellence. The process of implementing quality management activities has also increased provider awareness of the importance of QM, and has spurred inter-agency development of quality management programs. The Grantee's Specialized Workshop program - a series of skills-building trainings to assist service providers and supervisors in improving client care at their organizations - have proven so popular that their number has been increased from **four** trainings in 2005 to **eight** in 2006. Of course, the overwhelming objective of QM remains to ensure the ongoing quality of all Title I-funded services in our EMA, including ensuring that services adhere to PHS guidelines. Implementation of a comprehensive and effective quality management program has played a significant role in ensuring that local care services continue to adhere to the same high standard that has always been exemplified by our local system of care.

Ensuring an Information Loop Between Grantee and Planning Council: As noted above, the Director of HIV Health Services provides ongoing updates and information regarding quality management activities to the San Francisco HIV Health Services Planning Council. Additionally, the Quality Management Program Consultant and the HIV Health Services Data Systems Coordinator both provide formal progress reports to the Health Services Planning Council on the status of the quality management program and the client-level data system as part of the annual prioritization and allocation process. The Planning Council is notified of the quality management training schedule and is invited to attend workshops. Evaluations are completed for each training and an annual training progress report is submitted to HIV Health Services to monitor and improve the provider training component. Summaries of this training feedback are made available to the Planning Council. In addition, community-based agencies themselves report **directly** to the Planning Council on the progress of quality management activities, and the extent to which these activities are promoting enhanced care within their own agencies.

Projects to Improve Service Delivery: The narrative above describes a wide range of approaches to improving the quality of services in the EMA and through QM findings and processes. As noted above, QM findings have been used to ensure the ongoing quality of patient care; to track the utilization and impact of Title I resources; and to guide the initial allocation of Centers of Excellence resources. Quality management input has guided the content of training and technical assistance for local providers which in turn has significantly enhanced the quality of the entire system of care, and led last year to a grant from the Office of Minority Health to support a series of ambitious capacity building trainings specifically for local agencies serving communities of color. In 2004, HIV Health Services embarked on an aggressive effort to ensure universal compliance with Reggie data reporting by making receipt of client-level data a **pre-condition** of contract reimbursement. As a result of this effort, there has been a **39%**

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7.ii) UNMET NEED

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Methods for Estimating Met and Unmet Need for Primary Medical Care: In accordance with HRSA guidelines, PLWA and PLWH were considered to have a **met** need for HIV-related primary medical care if any data source indicated that they received antiretroviral therapy or had at least one CD4 or viral load test during the 12-month period from July 1, 2004 through June 30, 2005. We were able to generate separate unmet need estimates for PLWA and PLWH because all population and care data sources contained information on AIDS/HIV status.

The number of PLWA in care for Marin County was calculated as the number of unduplicated persons who received care based on all data sources. To determine the number of PLWA receiving care in San Francisco and San Mateo Counties, we calculated the proportion of PLWA in care using large, representative subsets of PLWA in each county (San Francisco County n=**5,525**, San Mateo County n=**639**). The proportion of PLWA in care was determined primarily based on chart review data and supplemented with care information from the other data sources. These samples excluded persons with incomplete care data, including those who were known to have moved out of the region or who were diagnosed by a medical care provider outside the jurisdiction. We applied the sample proportion of PLWA in care to the total number of PLWA to derive the number of PLWA who received care within each of these two counties.

For all counties in the EMA, the number of PLWH in care was calculated as the number of unduplicated persons who received care based on all data sources. Estimates for PLWA and PLWH were first derived separately for each of the three EMA counties and then combined to produce the EMA estimates shown in Table 6.

Findings: Estimates of Populations, Persons in Care and Unmet Need from July, 2004 through June, 2005: We estimate that there were **11,084** PLWA and **9,564** PLWH in the San Francisco EMA from July, 2004 through June, 2005 (see Table 6). A total of **1,027** PLWA and **2,882** PLWH did not receive primary medical care during that time period. Unmet need was thus **19%** overall, and - as would be expected - was higher among PLWH (**30%**) than among PLWA (**9%**). The 19% overall unmet need estimate is slightly higher than last year's estimate of 17%.

Limitations: The dataset obtained from the California Title II 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. Potential duplication of individuals is not a concern for our estimate of PLWH in care, since the latter was based on actual unduplicated counts.

c) Assessment of Unmet Need

Continually improving and refining the process of determining unmet need - and doing so in a manner that allows our local Planning Council to allocate funds in order to bring the greatest

number of out-of-care individuals into care - remains a high priority for the San Francisco EMA. This year's unmet needs estimation process utilized the most recent model approved by HRSA, and corrected minor discrepancies of clarity noted by HRSA in its response to our FY 2006 unmet needs estimate, none of which related to the actual numbers presented in our framework.

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. This year's consensus process, conducted between June 2005 and April 2006, 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 for the **first time** to utilize **HARS data only** as a basis for quantifying the total number of non-AIDS PLWH living in the city. This represents a major step forward - one that allows us to produce much more accurate and detailed representations of PLWH. Our ability to accurately quantify the local PLWH population is expected to improve over time, particularly given the new implementation of **confidential names-based HIV reporting** by the State of California this year - an approach that will give us a powerful new tool for unduplicating HIV cases among the EMA's three counties.

At the same time, our EMA continues to improve the data collection systems it utilizes to quantify the total number of HIV-infected persons in care throughout the region. Our continued close collaboration with the State of California Title II program and the San Francisco Veterans Administration allows us access to a number of key data sources that encompass **most** of the HIV-positive patients in care in our region, including HARS, Medi-Cal, the AIDS Drug Assistance Program (ADAP), and Kaiser Permanente Northern California, our region's largest provider of private HIV care. Our EMA is continuing to explore additional collaborative relationships with other private medical providers to obtain additional information on persons in care, in order to enhance the scope and comprehensiveness of our patient knowledge.

One of the immediate outcomes of our improved data collection and reporting systems is that we are now able to compare specific unmet need among PLWH/A from July 1, 2004 through June 30, 2005 across **three** primary demographic categories: **gender, race/ethnicity,** and **age group.** We have reported the results of this analysis in **Table 7** in Attachment 1. Defining the specific nature and composition of unmet needs populations will be invaluable in allowing the San Francisco HIV Health Services Planning Council to assess service needs and gaps among unmet needs groups, identify barriers to care, and involve and retain these persons in care on a long-term basis.

Among all PLWH/A populations, our analysis revealed 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. However, in terms of age, **young adults aged 20-29** were significantly more likely to have unmet need for medical care than those ago 30 and over (**38%** compared to **22%**), while significant unmet need also exists among persons **aged 30-39**, with **one-quarter (25%)** of the members 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 education and outreach programs in collaboration with regional prevention providers - programs that have consistently 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 specifically 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.

The San Francisco HIV Health Services Planning Council utilizes the results of the Unmet Needs Framework and related data to directly aid in planning and decision-making regarding priorities, resource allocations, and the local system of care. In 2003, for example, the San Francisco EMA conducted an analysis which utilized census tract data from HIV/AIDS case reports to determine unmet need by neighborhood among **11,057** San Francisco residents living with AIDS and HIV. This study found that the proportion of PLWH with unmet need for medical care was higher in lower-income neighborhoods such as **Ingleside, the Tenderloin, Bayview/Hunters Point,** and **Downtown** (median household income $21,347-$46,441). As might be expected, the absolute number of persons with unmet need was highest in neighborhoods where the largest number of PLWA and PLWH reside (e.g., the Castro and the Tenderloin, each with more than **2,000** PLWH/A). The city's Centers of Excellence program was created in part as a **direct response** to these observed inequities, creating community-based hubs of comprehensive care directly within hard-hit neighborhoods that have a higher proportion of lower-income out of care populations, such as the Southeast Partnership for Health located in the Bayview/Hunters Point community.

Also, as noted above, the San Francisco EMA completed a new **Comprehensive HIV/AIDS Health Services Needs Assessment** last year that was instrumental in guiding FY 2007 prioritization and funding allocation decisions by the San Francisco HIV Health Services Planning Council.[116] Among the key findings of the Assessment related to unmet need were the following: a) **60%** of survey respondents who stated that they were currently out of care were **African American**; b) **100%** of all out of care survey respondents stated that they were living at or below **150% of federal poverty level**; c) **23%** of out of care respondents were **female**; and d) of individuals who had been out of primary medical care for a year or more, only **18%** reported being on antiretroviral treatments, versus **75%** of the overall survey population. These findings led to strengthened funding request for Centers of Excellence programs specifically directed toward **African Americans** (Southeast Partnership for Health) and **women** (UCSF Women's Center of Excellence), while working in collaboration with local CoEs to extend local outreach efforts to out-of-care populations, while continuing to support Treatment Adherence to help complex and multiple needs populations remain in care.

Results of the FY 2006 Unmet Needs Framework analysis were presented to the San Francisco HIV Health Services Planning Council during the prioritization and allocation process, and played a critical role in helping influence and shape service category and funding decisions for FY 2007. For example, findings related to unmet need among ethnic minority populations helped to reinforce the approach of funding Centers of Excellence that create centralized service structures for severe need and hard-to-reach populations, particularly Latinos and African Americans. And findings related to unmet need among young people influenced the decision to continue to prioritize substance abuse services in this year's Title I

Plan, in order to address substance addiction barriers that can limit young people's willingness to access HIV testing and care. The Unmet Needs Framework remains a seminal document through which the Planning Council determines how best to allocate resources to bring more persons with HIV into care and to create service responses that meet the needs of expanding populations.

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ADVANCING A TRADITION OF EXCELLENCE:
SAN FRANCISCO EMA FY 2007 RYAN WHITE CARE ACT TITLE I
COMPETING CONTINUATION APPLICATION

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FOR ATTACHMENT 1

(NOTE: It is our understanding - based on information provided in the FY 2007 Title I Competing Continuation Guidance - that Tables of Contents for both the narrative and the attachment sections will not count toward the overall FY 2007 application page limit.)

SAN FRANCISCO, CALIFORNIA ELIGIBLE METROPOLITAN AREA
EMA ORGANIZATIONAL CHART

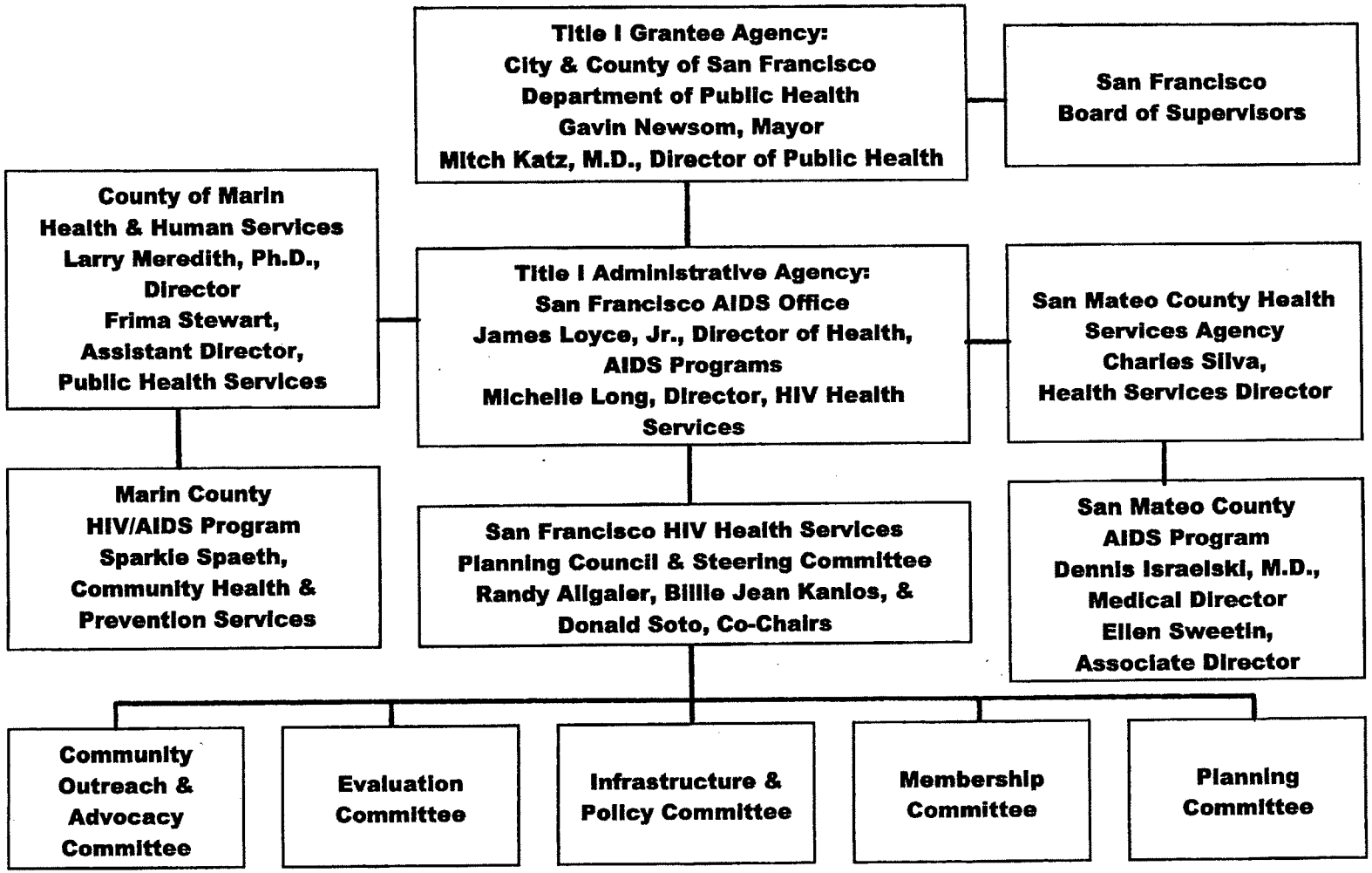


Table 1. San Francisco EMA FY 2007 HIV/AIDS Incidence and Prevalence Summary Table

Group / Exposure Category		New Diagnosed AIDS Cases - 1/1/04 - 21/31/05*		People Living with AIDS as of 12/31/05*		People Living with HIV (not AIDS) as of 12/31/05**		Combined Living with HIV & AIDS as of 12/31/05	
Race/Ethnicity	African American	159	17.5%	1647	15.1%	1724	14.7%	3371	14.9%
	Latino / Hispanic	190	20.9%	1677	15.3%	1654	14.1%	3331	14.7%
	Asian / Pacific Islander	54	6.0%	488	4.5%	534	4.6%	1022	4.5%
	White (not Hispanic)	493	54.4%	7046	64.4%	7303	62.4%	14349	63.4%
	Other / Multiethnic / Unknown	11	1.2%	83	0.8%	483	4.1%	566	2.5%
Gender	Female	85	9.4%	742	6.8%	872	7.5%	1614	7.1%
	Male	795	87.7%	9991	91.3%	10638	90.9%	20629	91.1%
	Transgender	27	3.0%	208	1.9%	188	1.6%	396	1.7%
Age* **	12 Years or Younger	0	0.0%	16	0.1%	22	0.2%	38	0.2%
	13 - 24 Years	27	3.0%	50	0.5%	267	2.3%	317	1.4%
	25 - 49 Years	678	74.8%	6588	60.2%	8564	73.2%	15152	66.9%
	Age 50 and Above	202	22.3%	4287	39.2%	2845	24.3%	7132	31.5%
Transmission Categories									
Men who Have Sex with Men (MSM)		557	61.4%	7680	70.2%	8243	70.5%	15923	70.3%
Injection Drug Users		117	12.9%	1164	10.6%	954	8.2%	2118	9.4%
MSM Who Inject Drugs		138	15.2%	1445	13.2%	1045	8.9%	2490	11.0%
Non-Injection Drug-Using Heterosexuals		51	5.6%	384	3.5%	447	3.8%	831	3.7%
Adult Other		1	0.1%	61	0.6%	33	0.3%	94	0.4%
Adult Risk Not Reported or Identified		43	4.7%	179	1.6%	936	8.0%	1115	4.9%
other with or at Risk for HIV (Pediatric)		0	0.0%	25	0.2%	30	0.3%	55	0.2%
Pediatric Other		0	0.0%	3	0.0%	10	0.1%	13	0.1%
TOTAL		**907**	**100.0%**	**10941**	**100.0%**	**11698**	**100.0%**	**22639**	**100.0%**

*AIDS data derived from epidemiological data reports prepared by the Marin, San Francisco, and San Mateo County health departments in August 2006. Please note that information contained in Table 1 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 in San Francisco and San Mateo Counties are 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 from HIV/AIDS experts and data, 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). The number of PLWH Marin County includes only HIV cases reported to the State of California since mandatory HIV reporting began in July 2002 that were known to be alive as of December 31, 2005.

***Throughout table, age for newly diagnosed is age at diagnosis, while age for people living with AIDS or HIV is age as of 12/31/05

Table 2. FY 2007 San Francisco EMA Cost and Complexity of Care Summary

Co-Factor / Co-Morbidity	Quantitative Totals	Per Capita Rates	Estimated Costs
Primary & Secondary Syphilis	2005 SF EMA cases: **262**[1] 2005 San Francisco only cases: **248** 2005 California Cases: **1,578**	SF EMA-wide: **15.46** per 100,000[2] San Francisco only: **31.2** per 100,000 California: **4.3** per 100,000	Total estimated annual costs related to new STI infections: **$26,722,000**[3] Total annual cost to treat new STI infections among persons living with HIV/AIDS: **$5,535,000**[4] Estimated cost to treat persons infected with HIV each year as a result of transmission facilitated through STIs:. **$75,000,000**[5]
Gonorrhea	2005 SF EMA cases: **2,770**[6] 2005 San Francisco only cases: **2,463** 2005 California Cases: **34,259**	SF EMA-wide: **163.4** per 100,000[7] San Francisco only: **309.9** per 100,000 California: **92.6** per 100,000	
Chlamydia	2005 SF EMA cases: **5,781**[8] 2005 San Francisco only cases: **3,797** 2005 California Cases: **130,290**	SF EMA-wide: **341.0** per 100,000[9] San Francisco only: **477.7** per 100,000 California: **352.1** per 100,000	
Homelessness	SF EMA Chronic Homeless: Approx. **13,500**[10] SF EMA Temporary / Short-Term Homeless: Approx. **13,140** Per Year Estimated Annual PLWH/A Homeless in SF EMA: **1,585**[11]	Combined Annual EMA-Wide Homelessness Rate: **1,571** per 100,000[12] Combined Annual EMA-Wide Homelessness Rate Among PLWH/A: **17,000** per 100,000[13]	Estimated additional cost of care for HIV-positive homeless persons: Min. **$19,020,000**[14]
Lack of Insurance Coverage (including persons without Medicaid)	SF EMA Percent Uninsured: **16.3%**[15] EMA Number Uninsured: **241,492** Percent of PLWH/A in Care in SF EMA Uninsured: **27%**[16] Estimated Number of PLWH/A in Care in SF EMA Uninsured: **4,869**[17]	Total EMA-wide Uninsured Rate: **14,245.5** per 100,000[18] Total EMA-wide Uninsured Rate Among PLWH/A in Care: **27,000** per 100,000[19]	Estimated cost of care for total uninsured population: **$217,584,292**[20] Estimated cost of care for uninsured PLWH/A: **$90,400,000**[21]
Percent Living at or Below 300% of 2005	Percent Living at or Below 300% of 2005 FPL in SF EMA: **47.72%**[22]	Total EMA-wide Rate of Persons Living at or Below 300% of 2005	Total est. annual cost of providing care to PLWH/A

Co-Factor / Co-Morbidity	Quantitative Totals	Per Capita Rates	Estimated Costs
Federal Poverty Level (FPL)	Number Living at or Below 300% of 2005 FPL in SF EMA: **808,917** Percent of all PLWH/A in SF EMA Living at or Below 300% of 2005 FPL: **66.5%**[23] Number of PLWH/A in SF EMA Living at or Below 300% of 2005 FPL: Min. **14,725**	FPL: **47,717** per 100,000[24] Total EMA-Wide Rate of PLWA/H in SF Living at or Below 300% of 2005 FPL: **66,500** per 100.000[25]	at or below 300% of 2005 FPL: **$131,328,490**[26]

[1] All statistics this cell: State of California Department of Health Services, STD Control Branch, "Primary and Secondary Syphilis, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2001-2005 Provisional Data," Sacramento, CA, Revised July 5, 2006.
[2] All statistics this cell: Ibid.
[3] Calculation based on average of $5,000 per capita for syphilis and gonorrhea treatment (262 and 2,770 new cases, respectively, in 2005) and $2,000 per capita for chlamydia treatment (5,781 new cases in 2005) in the first year following diagnosis.
[4] Calculation based on estimated 5% of annual citywide non-HIV STI cases occurring among people already living with HIV (n=1,107) at average treatment cost of $5,000 per capita.
[5] Calculation based on a total of 30 new HIV infections per year facilitated through other STIs at an annual treatment cost of $25,000 x 10 years per person.
[6] All statistics this cell: State of California Department of Health Services, STD Control Branch, "Gonorrhea, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2001-2005 Provisional Data," Sacramento, CA, Revised July 5, 2006.
[7] All statistics this cell: Ibid.
[8] All statistics this cell: State of California Department of Health Services, STD Control Branch, "Chlamydia, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2001-2005 Provisional Data," Sacramento, CA, Revised July 5, 2006.
[9] All statistics this cell: Ibid.
[10] This figure and the figure immediately below: 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.
[11] Calculation based on total 22,639 persons with HIV living in the EMA with a conservative annual homelessness rate of 7% (n=1,585).
[12] These and per capita estimates below based on 2003 Census population of 1,695,211 for the San Francisco EMA, contained in US Census Bureau, *California QuickFacts*, Marin, San Francisco, and San Mateo Counties, Revised July 9, 2004, http://quickfacts.census.gov.
[13] See Endnote # 11.

[14] Calculation based on total 22,639 persons with HIV living in the EMA with a conservative annual homelessness rate of 7% (n=1,585) and a minimum additional cost of $12,000 to meet these individuals' annual homeless-related needs.
[15] Percentage based on estimated uninsured rates provided in University of California, Los Angeles Center for Health Policy Research, *The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey,* Los Angeles, CA, August 2005, www.healthpolicy.ucla.edu
[16] Source: 2006 San Francisco EMA Reggie Data (Reggie is the client database and registration system used to track client characteristics and service utilization in San Francisco).
[17] Calculation based on current 27% uninsured rate among San Francisco HIV/AIDS clients in care, applied to 17,639 total persons in care in the San Francisco EMA as identified through the unmet needs framework.
[18] See Endnote # 12.
[19] See Endnote # 17.
[20] Based on Kaiser Family Foundation estimate of $901 average cost of annual care per non-elderly person in the US. Source: Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer - Key Facts About Americans Without Health Insurance,* Washington, DC, Revised November 2004, http://www.kff.org/uninsured/upload/7216%20Uninsured%20Primer_Revised_072805_new%20shell%20(2).pdf
[21] Estimate based on average 27% uninsured rate among persons living with HIV/AIDS in care (n=4,520) at an estimated annual average cost of $20,000 per person for HIV treatment and medications.
[22] This figure and the figure immediately below based on based on 2005 HHS Poverty Guidelines of $16,090 for 3-person household x 300% = $48,270 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 = 808,917 total persons living at 300% of FPL or below.
[23] This figure and figure immediately below based on 100% rate of PLWH/A in CARE system living at or below 300% of poverty (n=7,968) plus conservatively estimated 47.7% rate of 300% at or below FPL for all other PLWA/H (same as overall EMA-wide rate) (14,166 not in CARE system x .477 = 6,757)
[24] See Endnote # 12.
[25] See Endnote # 23.
[26] Calculation based on current annual projected EMA-wide HIV expenditures of $197,486,452 (see Table 4) x .665, representing estimated percentage of all persons with HIV/AIDS living in poverty.

Table 3. San Francisco EMA FY 2007 Title I Service Allocations - Top Six Service Categories by Funding Requested
March 1, 2007 - February 28, 2008

Description of Services & Objectives	Individual Service Unit Measure	Quantity		FY 2007 Funding Requested	% of Total Service Request
		# of People	Service Units		
1: AMBULATORY / OUTPATIENT MEDICAL CARE. **GOAL: To improve the health status and extend the quality and length of life of people with HIV/AIDS who have low incomes by ensuring access to a continuum of high-quality, accessible, and culturally competent health care services.**					
Sub-Category: Primary Medical Care: **Objective:** Between March 1, 2007 and February 28, 2008, to provide at least **46,755** units of comprehensive ambulatory and outpatient medical services (including patient outreach and TB testing) by HIV specialists at hospital-based and community-based clinics, including Centers of Excellence, with an emphasis on underserved populations and PLWH with complex medical conditions.	**Primary Care Encounter or Hour of Related Services**	**7,616**	**46,755**	**$ 7,199,634**	**33.0%**
2: HOUSING SERVICES **GOAL: To secure stability, improve health status, and extend the quality and length of life of people with HIV/AIDS who are homeless and have low incomes by providing access to essential emergency, transitional, and supportive housing programs for individuals and families.**					
Sub-Category: Emergency Housing: **Objective:** Between March 1, 2007 and February 28, 2008, to subsidize **301** emergency hotel stays of a maximum of four weeks in order to assist individuals and families facing an immediate housing crises and help them stabilize medically, emotionally, and financially.	**Month at an Emergency Hotel**	**301**	**301**	**$ 197,055**	**0.6%**
Sub-Category: Residential Programs and Subsidies: **Objective:** Between March 1, 2007 and February 28, 2008, to provide direct housing services and support for rental assistance and subsidies designed to assist at least **653** clients in stabilizing and maintaining health and quality of life, in a manner that is fully linked with medical,	**Rental Subsidy Day and Related Supportive Housing**	**653**	**200,274**	**$ 4,791,743**	**15.3%**

Description of Services & Objectives	Individual Service Unit Measure	Quantity		FY 2007 Funding Requested	% of Total Service Request
		# of People	Service Units		
psychosocial, and case management services, and which is geared to promote client empowerment and self-sufficiency.	**Service Hrs.**				
Sub-Category: Transitional Housing: **Objective:** Between March 1, 2007 and February 28, 2008, to provide a total of **4,234** days of short-term residential and transitional housing services designed to stabilize individuals medically, emotionally, and economically while supporting a transition to long-term, sustainable housing, including through integration of substance abuse, mental health, case management, and other critical services.	**Supportive Housing Day**	**33**	**4,234**	**$ 337,451**	**1.1%**
3: SUBSTANCE ABUSE SERVICES **GOAL: To stabilize the lives and improve the health status of people with HIV/AIDS by ensuring that low-income substance abusing and/or chemically addicted people with HIV/AIDS receive appropriate, culturally competent substance abuse treatment services.**					
Sub-Category: Residential Substance Abuse Treatment: **Objective:** Between March 1, 2007 and February 28, 2008, to provide access to a range of essential residential substance abuse treatment services for **345** unduplicated clients, including congregate detoxification, drug treatment, and treatment aftercare services using harm reduction models, with an emphasis on multiply diagnosed populations, women, people of color, youth, and gay men.	**Bed Day**	**345**	**25,689**	**$ 3,128,376**	**10.0%**
Sub-Category: Drug Detoxification Services: **Objective:** Between March 1, 2007 and February 28, 2008, to provide access to crisis-based substance and chemical detoxification services, including medical detoxification services, for at least **126** multiply diagnosed and homeless people, with all services linked to primary care.	**Bed Day**	**126**	**2,783**	**$ 389,514**	**1.3%**

Description of Services & Objectives	Individual Service Unit Measure	Quantity		FY 2007 Funding Requested	% of Total Service Request
		# of People	Service Units		
Sub-Category: Outpatient Substance Services: **Objective:** Between March 1, 2007 and February 28, 2008, to provide at least **34,306** units of individual and/or group outpatient treatment, counseling, and support services for underserved and high-needs substance-addicted populations, with services linked to primary medical care and other essential service programs.	**Hour**	**361**	**34,306**	**$ 493,057**	**1.6%**
4: CASE MANAGEMENT **GOAL: To stabilize the lives and improve the health status of people with HIV/AIDS who have low incomes by providing access to high-quality, culturally competent, and fully integrated case management services that ensure access to all needed health and supportive services.**					
Sub-Category: Case Management: **Objective:** Between March 1, 2007 and February 28, 2008, to provide direct one-on-one case management services to at least **9,176** unduplicated clients that link and coordinate assistance from multiple agencies and caregivers providing psychosocial, medical, and practical support services, in order to assist clients in attaining the highest level of independence and quality of life consistent with their functional capacity and preferences for care.	**Hour**	**9,176**	**44,325**	**$ 2,458,845**	**7.8%**
Sub-Category: Residential Case Management: **Objective:** Between March 1, 2007 and February 28, 2008, to provide at least **21,063** hours of case management services similar to those described immediately above, but within the setting of residential and housing programs supported through Ryan White Title I funding, with an emphasis on multiply diagnosed populations.	**Hour**	**987**	**21,063**	**$ 1,168,421**	**3.7%**
Sub-Category: Integrated Case Management: **Objective:** Between March 1, 2007 and February 28, 2008, to provide at least **1,654** hours of case management services similar to those	**Hour**	**87**	**1,654**	**$ 99,422**	**0.3%**

Description of Services & Objectives	Individual Service Unit Measure	Quantity		FY 2007 Funding Requested	% of Total Service Request
		# of People	Service Units		
described immediately above, but with the addition of treatment advocacy and peer advocacy services for multiply-diagnosed clients facing complex life needs and treatment adherence barriers.					
5: MENTAL HEALTH SERVICES **GOAL: To stabilize the lives and improve the health status of people with HIV/AIDS who have low incomes and are facing mental illness or mental health issues by providing accessible, appropriate, and culturally competent mental health treatment services.**					
Sub-Category: Crisis Mental Health: **Objective:** Between March 1, 2007 and February 28, 2008, to provide a minimum of **6,081** units of emergency and crisis psychiatric intervention services to preserve client health, including the services of a suicide prevention hotline and access to emergency psychiatric care.	**Hour or Telephone Call**	**2,231**	**6,081**	**$ 472,771**	**1.5%**
Sub-Category: Outpatient Mental Health: **Objective:** Between March 1, 2007 and February 28, 2008, to provide at least **23,760** total units of psychosocial and psychiatric mental health treatment and counseling services in group or individual settings for people with one or more diagnosed mental illnesses, provided by a mental health professional licensed or authorized within the State to render such services.	**Hour**	**1,521**	**23,760**	**$ 2,149,835**	**6.9%**
Sub-Category: Residential Mental Health: **Objective:** Between March 1, 2007 and February 28, 2008, to provide at least **6,278** total units of mental health and related services - including dementia care - delivered within residential settings for people with severe mental illness, with an emphasis on multiply-diagnosed populations.	**Bed Day**	**151**	**6,278**	**$ 632,885**	**2.0%**

Description of Services & Objectives	Individual Service Unit Measure	Quantity		FY 2007 Funding Requested	% of Total Service Request
		# of People	Service Units		
6: HOME HEALTH: PROFESSIONAL CARE **GOAL: To maintain and improve the health status of people with HIV/AIDS who have low incomes by providing access to high-quality, culturally competent home-based professional health services.**					
Sub-Category: Facility-Based Home Care: **Objective:** Between March 1, 2007 and February 28, 2008, to provide at least **16,276** total days of supervised or assisting living support within licensed residential settings to people with HIV who are no longer able to live independently in the community, with the goal of helping these clients maintain their level of functioning through assistance with daily needs, including therapeutic, nursing, and supportive health services.	**Professional, Para-professional, and/or Specialized Patient Day**	**171**	**16,276**	**$ 1,453,684**	**4.6%**
Sub-Category: Home-Based Home Care: **Objective:** Between March 1, 2007 and February 28, 2008, to provide at least **3,289** total days of supervised or assisting living support that helps maintain people with HIV in their homes and supports their level of functioning through assistance with daily needs and/or through the provision of routine or skilled home-based nursing services.	**Attendant Care Day, Homemaker Service Day, RN/MSW Professional Visit, and/or Specialized Patient Day**	**83**	**3,289**	**$ 399,058**	**1.3%**
TOTAL - TOP SIX FY 2007 CATEGORIES BY FUNDING AMOUNT				**$ 25,371,751**	**80.9%**

Table 4. San Francisco EMA Projected Other Public Funding - March 1, 2007 - February 28, 2008

SERVICES	Amount and Percent of Public Funding by Source									
	Ryan White Title I		Other Federal Funds		State Funds		Local Funds		TOTAL FUNDS	
	Funds	%	Funds	%	Funds	%	Funds	%	Funds	%
Ambulatory / Outpatient Medical Care	$ 6,030,276	3.1%	$13,048,187	6.6%	$ 3,886,439	2.0%	$ 2,535,623	1.3%	$ 25,500,525	12.9%
State AIDS Drug Assistance Programs (ADAPs)	$ -	0.0%	$ -	0.0%	$24,958,880	12.6%	$ -	0.0%	$ 24,958,880	12.6%
Home and Community-Based Support Services	$ 10,352,892	5.2%	$ 9,251,734	4.7%	$ -	0.0%	$ 2,414,355	1.2%	$ 22,018,981	11.1%
Other Outpatient / Community-Based Primary Medical Care	$ 5,273,308	2.7%	$32,844,920	16.6%	$33,059,513	16.7%	$ 6,921,285	3.5%	$ 78,099,026	39.5%
Inpatient Medical Care Services	$ -	0.0%	$18,382,052	9.3%	$10,277,495	5.2%	$ 2,181,123	1.1%	$ 30,840,670	15.6%
Substance Abuse / Mental Health Services	$ 6,308,388	3.2%	$ 487,805	0.2%	$ -	0.0%	$ 9,272,177	4.7%	$ 16,068,370	8.1%
TOTAL	**$ 27,964,864**	**14.2%**	**$74,014,698**	**37.5%**	**$72,182,327**	**36.6%**	**$23,324,563**	**11.8%**	**$197,486,452**	**100.0%**

Table 5. San Francisco EMA Comparison of FY 2006 & F7 2006 Title I Service Priorities and Allocations

(NOTE: While the Planning Council did not develop specific language regarding how FY 2007 priorities should be met, services within Centers of Excellence (*) are designed to provide improved access, care, and treatment retention for growing populations of complex, hard-to-reach, and multiply diagnosed people with HIV.)

Rank	FY 2006 Service Priorities & Allocations	Rank	FY 2007 Service Priorities & Requested Funding
1	**Ambulatory / Outpatient Medical Care**, including Primary Medical Care within Centers of Excellence FY 2006 Amount Funded - **$5,950,111**	1	**Ambulatory / Outpatient Medical Care**, including Primary Medical Care within Centers of Excellence* FY 2007 Requested Amount - **$7,199,634**
2	**AIDS Pharmaceutical Assistance** - Not Funded through Title I due to high level of State and local medication reimbursement	2	**AIDS Pharmaceutical Assistance** - Not Funded through Title I due to high level of State and local medication reimbursement
3	**Housing Assistance**, including Emergency Housing, Residential Progs. & Subsidies, & Transitional Housing FY 2006 Amount Funded – **$4,401,858**	3	**Housing Assistance**, including Emergency Housing, Residential Progs. & Subsidies, & Transitional Housing FY 2007 Requested Amount - **$5,326,249**
4	**Mental Health Services**, including Crisis Mental Health, Outpatient Mental Health, & Residential Mental Health FY 2006 Amount Funded - **$2,690,489**	4	**Mental Health Services**, including Crisis Mental Health, Outpatient Mental Health*, & Residential Mental Health FY 2007 Requested Amount - **$3,255,491**
5	**Case Management**, including Case Management, Residential Case Management, & Integrated Case Management FY 2006 Amount Funded - **$3,079,907**	5	**Case Management**, including Case Management*, Residential Case Management, & Integrated Case Management FY 2007 Requested Amount - **$3,726,688**
6	**Oral Health Care** (Centralized Dental Care) FY 2006 Amount Funded - **$742,468**	6	**Oral Health Care** (Centralized Dental Care) FY 2007 Requested Amount - **$898,386**
7	**Emergency Financial Assistance** FY 2006 Amount Funded - **$704,106**	7	**Emergency Financial Assistance** FY 2007 Requested Amount - **$852,017**
8	**Client Advocacy**, including Benefits Counseling & Money Management FY 2006 Amount Funded - **$1,114,830**	8	**Client Advocacy**, including Benefits Counseling & Money Management* FY 2007 Requested Amount - **$1,348,944**

Rank	FY 2006 Service Priorities & Allocations	Rank	FY 2007 Service Priorities & Requested Funding
9	**Food Bank / Home Delivered Meals** FY 2006 Amount Funded - **$1,572,357**	9	**Food Bank / Home Delivered Meals** FY 2007 Requested Amount - **$1,902,552**
10	**Inpatient Substance Abuse Services**, including Residential Substance Abuse Treatment & Detoxification FY 2006 Amount Funded - **$2,907,347**	10	**Inpatient Substance Abuse Services**, including Residential Substance Abuse Treatment & Detoxification FY 2007 Requested Amount - **$3,517,890**
11	**Home Health Care**, including Facility-Based Home Health Care & Home-Based Home Health Care FY 2006 Amount Funded - **$1,531,192**	11	**Home Health Care**, including Facility-Based Home Health Care & Home-Based Home Health Care FY 2007 Requested Amount - **$1,852,742**
12	**Outpatient Substance Abuse Services** FY 2006 Amount Funded - **$407,485**	12	**Outpatient Substance Abuse Services*** FY 2007 Requested Amount - **$493,057**
13	**Legal Services** FY 2006 Amount Funded - **$74,800**	13	**Legal Services** FY 2007 Requested Amount - **$90,508**
14	**Treatment Adherence Services** FY 2006 Amount Funded - **$338,067**	14	**Treatment Adherence Services*** FY 2007 Requested Amount - **$409,061**
15	**Transportation** FY 2006 Amount Funded - **$5,000**	15	**Transportation** FY 2007 Requested Amount - **$6,050**
16	**Complementary Therapies** FY 2006 Amount Funded - **$151,633**	16	**Complementary Therapies** FY 2007 Requested Amount - **$183,476**
17	**Day / Respite Care** FY 2006 Amount Funded - **$0**	17	**Day / Respite Care** FY 2007 Requested Amount - **$0**
18	**Outreach Services** FY 2006 Amount Funded - **$205,790**	18	**Outreach Services*** FY 2007 Requested Amount - **$249,006**
19	**Child Care Services** FY 2006 Actual Amount Funded - **$0**	19	**Child Care Services** FY 2007 Requested Amount - **$0**
20	**Buddy / Companion Services** FY 2006 Amount Funded - **$40,000**	20	**Buddy / Companion Services** FY 2007 Requested Amount - **$48,400**

Table 6. San Francisco EMA Unmet Need Calculation - July 1, 2004 through June 30, 2005

Col. 1	Column 2	Col. 3	Col. 4	Column 5
Population Sizes		**Value**		**Data Source(s)**
A	Number of persons living with AIDS (PLWA) from July 1, 2004 through June 30, 2005	**11,084**		HARS counts (all EMA counties)
B	Number of persons living with HIV (PLWH)/non-AIDS/aware from July 1, 2004 through June 30, 2005	**9,564**		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, 2004 through June 30, 2005	**20,648**		Value = A + B
Care Patterns		**Value**		**Data Source(s)**
D	Number of PLWA who received the specified HIV primary medical care from July 1, 2004 through June 30, 2005	**10,057**		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, 2004 through June 30, 2005	**6,682**		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, 2004 through June 30, 2005	**16,739**		Value = D + E
Calculated Results		**Value**	**%**	**Calculation**
G	Number of PLWA who did not receive the specified HIV primary medical care	**1,027**	**9%**	Value = A - D; Percent = G / A
H	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	**2,882**	**30%**	Value = B - E; Percent = H / B
I	Total HIV+/aware not receiving specified HIV primary medical care	**3,909**	**19%**	Value = G + H; Percent = I / C (quantified estimate of unmet need)

Table 7. San Francisco EMA Demographic Analysis of People in and Out of Care July 1, 2004 through June 30, 2005: ALL Persons Living with HIV or AIDS (PLWH/A)*

Characteristic	#1: PLWA/H Population	#2: Number with Met Need	#3: Number with Unmet Need	#4: % of Unmet Need Population**	#5: % of Category with Unmet Need**	#6: % of Total PLWA/H Population**
All PLWA/H	20,648	16,739	3,909	100%	19%	100%
HIV/AIDS Status						
PLWA	11,084	10,057	1,027	26%	9%	54%
PLWH/no AIDS	9,564	6,682	2,882	74%	30%	46%
Gender						
Male	18,971	15,366	3,605	92%	19%	92%
Female	1,677	1,373	304	8%	18%	8%
Race/Ethnicity:						
White	13,118	10,642	2,476	63%	19%	63%
African American	3,091	2,511	580	15%	19%	15%
Latino	3,034	2,432	602	15%	20%	15%
Asian/PI	999	817	182	5%	18%	5%
Other	406	337	69	2%	17%	2%
Age in Years:						
0-19	106	76	30	1%	28%	<1%
20-29	926	574	352	9%	38%	5%
30-39	4,604	3,466	1,138	29%	25%	22%
40-49	8,534	7,033	1,501	38%	18%	41%
50-59	5,003	4,303	700	18%	14%	24%
60 or older	1,475	1,287	188	5%	13%	7%

* Excludes PLWH (non-AIDS) not aware of their HIV status.

** Column calculations: Column #4 = Column #3 / total with unmet need (n=3,909); Column #5 = Column #3 / Column #1; Column #6 = Column #1 / total number PLWH/A (n=20,648).

ADVANCING A TRADITION OF EXCELLENCE:
SAN FRANCISCO EMA FY 2007 RYAN WHITE CARE ACT TITLE I
COMPETING CONTINUATION APPLICATION

TABLE OF CONTENTS
FOR ATTACHMENT 2

(NOTE: It is our understanding - based on information provided in the FY 2007 Title I Competing Continuation Guidance - that Tables of Contents for both the narrative and the attachment sections will not count toward the overall FY 2007 application page limit.)

San Francisco HIV Health Services Planning Council

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

September 20, 2006

Douglas Morgan, M.P.A.
Director, Division of Service Systems
HIV/AIDS Bureau, HRSA
5600 Fishers Lane, Room 7A-55
Rockville, Maryland 20857

Dear Mr. Morgan:

This letter is to provide HRSA with assurance that the San Francisco HIV Health Services Planning Council (hereinafter referred to as the Planning Council) has fulfilled the following mandated roles and responsibilities in relation to its continuing HRSA Title I grant to the San Francisco, California EMA:

- FY 2006 Formula and Supplemental funds awarded to the EMA are being expended according to the priorities established by the Planning Council, and all FY 2006 Conditions of Award for the Formula and Supplemental grants to the EMA related to the Planning Council have been addressed;
- FY 2007 priorities described in this application were determined by the Planning Council, and approved processes for establishing those priorities were utilized by the Planning Council;
- Planning Council membership training has taken place; and
- The membership of the San Francisco HIV Health Services Planning Council continues to be representative and reflective of the HIV epidemic in the EMA. At the present time, the Council has two deficiencies in required categories, both due to recent, unexpected resignations. One is the Council's Medi-Cal representative, and the other the dental representative. The Council is currently recruiting for these positions and expects to have replacement members seated by the end of the calendar year. The Council is also reviewing membership applications for five new consumer members, and a new Native American representative.

Thank you for your continuing support of the San Francisco HIV Health Services Planning Council and our EMA's efforts to continue providing effective, comprehensive, and cost-efficient services to low-income and severely affected persons living with HIV/AIDS in our region.

Sincerely,

Randy Allgaier
Co-Chair

Billie Jean Kanios
Co-Chair

Donald Soto
Co-Chair

415-674-4768 | 730 Polk Street, 3rd Floor, San Francisco CA 94109 | 415-674-0371fax
www.sfcarecouncil.org

INTERGOVERNMENTAL AGREEMENTS (Signature Pages)

IN WITNESS WHEREOF, the parties hereto have executed this Agreement the day and year first herein above mentioned.

RECOMMENDED;

MITCHELL H. KATZ, M.D.
Director, Department of Health

APPROVED AS TO FORM
Dennis J. Herrera, City Attorney

By _____
Deputy City Attorney

APPROVED:
Grantee:

County of San Mateo

President, Board of Supervisors
(Title)

(Signature)

[redacted]
Federal ID or Social Security No.

Certificate of Delivery
(Government Code Section 25103)
I certify that a copy of the original document filed in the Office of the Clerk of the Board of Supervisors of San Mateo County has been delivered to the President of the Board of Supervisors.

Deputy Clerk of the Board of Supervisors

IN WITNESS WHEREOF, the parties hereto have executed this Agreement the day and year first herein above mentioned.

RECOMMENDED;

MITCHELL H. KATZ, M.D.
Director, Department of Health

APPROVED AS TO FORM
Dennis J. Herrera, City Attorney

By _____
Deputy City Attorney

APPROVED:
Grantee:

County of Marin

President, Board of Supervisors
(Title)

(Signature)

[redacted]
Federal ID or Social Security No.

FY 2007 Agreements and Compliance Assurances

The Chief Elected Official (CEO) of the Eligible Metropolitan Area (EMA), or her/his designee, must include a signed copy of the attached form with the Title I grant application. This form lists the program assurances, which must be satisfied in order to qualify for a Title I Grant as required under the CARE Act.

RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY ACT AMENDMENTS OF 2000 TITLE I HIV EMERGENCY RELIEF GRANT PROGRAM
FY 2007 Agreements and Compliance Assurances

I, the Chief Elected Official of the Eligible Metropolitan Area (hereinafter referred to as the

EMA) - San Francisco EMA,
designated pursuant to the provision of Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 as amended, hereby certify that:

A. as required in Section 2604 (a)(1) and (2):

the allocation of funds and services within the EMA will be made in accordance with the priorities established, pursuant to **Section 2602 (b)(4)(C)**, by the HIV Health Services Planning Council that serves the EMA; and
funds provided under **Section 2601** will be expended only for the purposes described in **Sections 2604 (b) and (c)**

B. as required in **Section 2605 (a):**

1. funds received under this Title will be used to supplement, not supplant, State funds made available in the year for which the grant is awarded to provide HIV-related services to individuals with HIV disease;
2. During the grant period, political subdivisions within the EMA will maintain at least their prior fiscal year's level of expenditures for HIV-related services for individuals with HIV disease ;
3. political subdivisions within the EMA will not use funds received under this Title in maintaining the level of expenditures for HIV-related services as required in the above paragraph (2); and,
4. documentation of this Maintenance of Effort is required.

C. the EMA:

1. pursuant to Section 2602(b) has an HIV Health Services Planning Council that:

a. is reflective of the demographics of the epidemic, with particular consideration given to disproportionately affected and historically underserved groups and

subpopulations, and is inclusive of representatives from all categories cited in the legislation;

b. is not chaired solely by an employee of the grantee **(Section 2602(b)(7)(A));**

c. maintains an open process for member nominations, with candidates selected based on locally delineated and publicized criteria, including a conflict-of-interest standard **(Section 2602(b)(1));**

d. is not directly involved in the administration of grants and does not designate (or is not otherwise involved in the selection of) particular entities as recipients of this grant, in accordance with HRSA/HAB guidance on Planning Council Roles and Responsibilities, and that individuals on the Council will not participate in the process of selecting entities to receive funds if that person has a financial interest in the entity, is an employee of that entity, or is a member of such entity (Section 2602(b)(5)(A));

e. has procedures for addressing grievances with respect to priority setting and allocation of resources, including procedures for submitting grievances that cannot be resolved to binding arbitration, and are consistent with models developed by HRSA **(Section 2602(b)(6));**

f. has documented the duties of the Council consistent with Section 2602(b)(4);

g. has incorporated or referenced all of the above provisions in the Planning Council by-laws or operating procedures;

h. has ensured that meetings of the Planning Council are open to all members of the general public, and that there is a system to ensure public announcement of all meetings (Section 2602 (b)(7)(B));

i. has ensured that Planning Council minutes must be certified by the Planning Council Chair and made available to the public no later than two weeks after they have been approved by the Planning Council or the Executive Committee. (The entire process should take no more than six weeks);

j. has ensured that the Planning Council has a location, accessible by the public, where minutes and related information can be inspected and copied if requested (Section2602 (b)(7)(B));

k. has taken steps to guard against disclosure of personal information that would constitute an invasion of privacy, including medical or other personnel matters that should not be discussed (Section 2602 (b)(7)(B));

l. has taken steps to ensure that when Planning Council committees or subgroups make recommendations or take actions subject to Planning Council review or ratification, records of the proposed recommendations and actions should be made available for public inspection;

m. has noted that in situations where the State, County or local statute, ordinance or regulation is more stringent than the legislative language cited above, those statutes or ordinances take precedence — otherwise, the new provisions contained in the Reauthorized CARE Act take precedence;

n. has noted that as a condition of award, the grantee is required to notify HRSA of any changes in Planning Council Composition and associated Reflectiveness within 30 days of the change.

2. has entered into intergovernmental agreements pursuant to Section 2602(a), with the CEOs of the political subdivisions in the EMA that provide HIV-related health services and for which the number of AIDS cases in the last five years constitutes not less than 10 percent of the cases reported for the EMA; and

3. has developed a comprehensive plan for the organization and delivery of health services to individuals with HIV disease, in accordance with **Section 2602 (b)(4)(D).**

4. has ensured that CARE Act funded entities within the EMA maintain appropriate relationships with entities considered key points of access to the healthcare system for the purpose of facilitating early-intervention services for individuals diagnosed as being HIV positive **(Section 2605 (a)(3));**

D. As required in Section 2605 (a)(5): entities within the EMA that receive Title I funds shall participate in an established HIV community-based continuum of care, if such continuum exists within the EMA.

E. pursuant to **Section 2605(a)(6)**, Title I funds will not be used to pay for any item or service that can reasonably be expected to be paid:

1. under any State compensation program, insurance policy, or any Federal or State health benefits program or
2. by an entity that provides health services on a prepaid basis.

F. pursuant to Section 2605(a)(7) to the maximum extent practicable, that:

1. HIV primary medical care and support services provided with assistance made available under this Title will be provided without regard to:

   a. the ability of the individual to pay for such services or

   b. the current or past health conditions of the individuals to be served;

2. Such services will be provided in a setting that is accessible to low-income individuals with HIV disease; and

3. A program of outreach services will be provided to low-income individuals with HIV disease to inform them of such services.

G. in the provision of services with assistance provided under Title I, any charges for services will be made in accordance with the provisions specified in Section 2605(e).

H. pursuant to Section 2604(f)(1) and in accordance with the legislative definition of administrative activities (Sections **2604(f)(2) and (3),** will maintain administrative costs of the grantee at no more than 5 percent of the grant; and, of the funds allocated to entities, will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

I. pursuant to **Sections 2602(b)(6), (c)(1) and (2),** has developed grievance procedures with respect to funding that are determined by HRSA to be consistent with its model procedures, including a process for submitting grievances to binding arbitration.

J. pursuant to **Section 2604(b)(4)(A),** unless waived by the Secretary, grant funds of not less than the percentage of Women, Infants, Children and Youth with AIDS to the total population of persons with AIDS in the EMA shall be used to provide health and support services to each population with HIV disease, including treatment measures to prevent the perinatal transmission of HIV.

K. pursuant to **Section 2605(a)(8),** agrees to participate in the Statewide Coordinated Statement of Need process initiated by the State, and ensure that the services provided under the EMA's comprehensive plan are consistent with the SCSN.

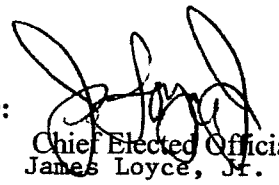
L. pursuant to the Minority AIDS Initiative, agrees that MAI funds will be expended in a manner consistent with legislative intent.

M. pursuant to **Section 2602(e)**, assures that Planning Council member training, based on the plan submitted in the application will take place.

N. pursuant to Section **2604(c)(1)**, assures that Quality Management Programs that meet HRSA requirements are in place.

O. pursuant to Section **2604(d)**, assures that personnel needs meet expenditure limitations.

P. pursuant to Section **2604(e)**, assures compliance with Medicaid provider requirements.

SIGNED: 

Chief Elected Official
James Loyce, Jr.

Title: Deputy Director of Health, Director of AIDS Programs

Eligible Metropolitan Area: San Francisco

Date: 9/14/06

Maintenance of Effort

The San Francisco EMA calculates its maintenance of effort (MOE) as the greater of fifty percent of the total CARE Title I award amount or the previous year's MOE. In 2006, the MOE commitment was $16,714,139 or 59.7% of our total award of $27,964,864 and greater than our MOE for 2005. San Mateo and San Francisco Counties' contributions to the MOE increased while Marin County's MOE remained level to the previous year. There were no changes from the data set relative to 2005. The elements determining the EMA MOE are listed below:

County	Account code	Amount	Budget Elements
San Mateo	Ending in 14	$422,180	Salaries and Contract Services
Marin	531	$853,296	Salaries and Operating Expenses
San Francisco	HCHPDHIVSVGF	$6,980,108	All of Index Code
San Francisco	HCHPDAIDRPRGF	$3,576,331	Professional and Specialized Services
San Francisco	HCHPDADMINGF	$1,018,700	All of Index Code
San Francisco	HCHPDEPIEVGF	$622,111	All of Index Code
San Francisco	HCHSHHOUSGGF	$2,006,218	Contract Services
San Francisco	HCPD15	$843,000	Contract Services
San Francisco	HCPD14	$392,195	Salaries
SAN FRANCISCO EMA TOTAL MOE		**$16,714,139**	

The following table "San Francisco EMA CARE Title I and Local Contribution Comparison Summary" represents the year-to-year HIV-related expenditures for CARE Title I funds and local general funds from fiscal year 1999 through fiscal year 2006. It documents that the overall level of HIV-related expenditures has been maintained for eight years.

San Francisco EMA CARE Title I and Local Contribution Comparison Summary								
	1999	2000	2001	2002	2003	2004	2005	2006
Care Title I	$36,218,513	$35,246,477	$35,771,651	$33,561,470	$33,941,235	$29,849,780	$28,297,777	$27,964,864
Local Contribution	$13,382,869	$14,189,866	$14,215,781	$14,788,589	$15,557,425	$15,632,685	$15,633,770	$16,714,139

The graph below visually demonstrates the San Francisco EMA's compliance with the maintenance of effort requirements over sixteen years.

Maintenance of Effort