FURTHERING A LIFE-SAVING LEGACY:
SAN FRANCISCO EMA FY 2014 RYAN WHITE PART A
COMPETING CONTINUATION APPLICATION NARRATIVE
TABLE OF CONTENTS

FURTHERING A LIFE-SAVING LEGACY:
SAN FRANCISCO EMA FY 2014 RYAN WHITE PART A
COMPETING CONTINUATION APPLICATION NARRATIVE

"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance, will have unfettered access to high-quality, life-extending care, free from stigma and discrimination."[1]

- Vision for the National HIV/AIDS Strategy, July 2010

NEEDS ASSESSMENT

1) DEMONSTRATED NEED

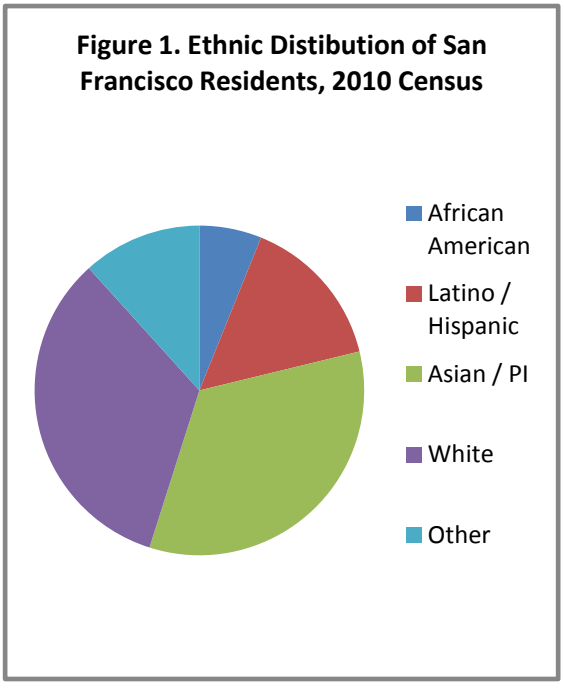
Introduction to the San Francisco EMA

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. 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 end, 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 challenges for those attempting to move between the county's eastern and western sides. The San Francisco (SF) EMA is also unusual because of the dramatic difference in the size of its member counties. While Marin and San Mateo Counties have a land area of **520** and **449** square miles, respectively, San Francisco County has 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 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 Board of Supervisors allows for a streamlined service planning and delivery process.

According to 2010 US Census data, the total population of the San Francisco EMA is **1,776,095**.[2] This includes a population of **252,409** in Marin County, **805,235** in San Francisco County, and **718,451** in San Mateo County, with widely varying population densities within the three regions. While the density of Marin County is **485** persons per square mile, the density of San Francisco County is **17,170 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 **1,602** persons per square mile is still more than ten times lower than its neighbor county to the north. These differences necessitate varying approaches to HIV care in the EMA.

The geographic diversity of the San Francisco EMA is reflected in the diversity of the people who call the area home. Over **half** of the EMA's residents (**53.3%**) are persons of color, including Asian/Pacific Islanders (**26.7%**), Latinos (**19.3%**), and African Americans (**4.3%**). In San Francisco, persons of color make up **58.1%** of the total population, with Asian residents alone making up over **one-third (33%)** of the city's total population (see Figure 1). The nation's largest population of Chinese Americans lives in the City of San Francisco, joined by a diverse range of Asian immigrants, including large numbers of Japanese, Vietnamese, Laotian, and Cambodian residents. A large number of Latino immigrants also reside in the EMA, including

native residents of Mexico, Guatemala, El Salvador, and Nicaragua. EMA-wide, **31.6%** of residents were born outside the US and **41.7%** of residents speak a language other than English at home with over **100** separate Asian dialects alone spoken in SF. 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. A total of over **20,000** new immigrants join the EMA's population each year, in addition to at least **75,000** permanent and semi-permanent undocumented residents.



1.A) HIV/AIDS Epidemiology

1.A.1) HIV/AIDS Epidemiology Table -

See **Table** in **Attachment 3**

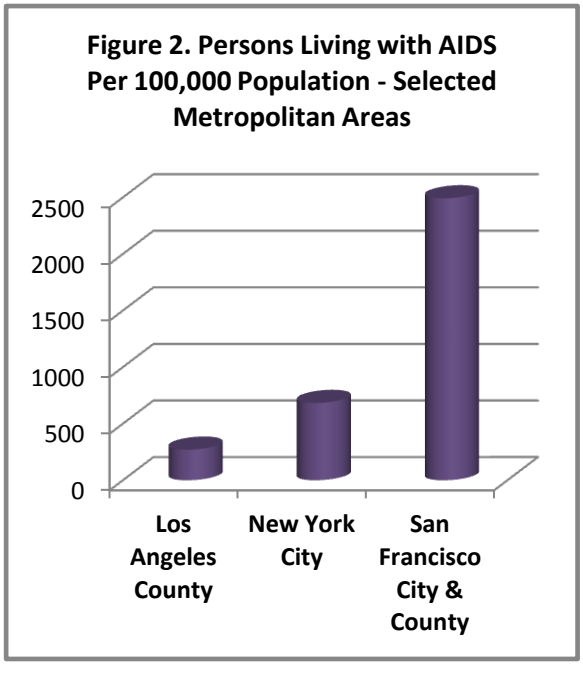
1.A.2) HIV/AIDS Epidemiology Narrative

Description of Current HIV/AIDS Cases:

More than a quarter century into the HIV epidemic, the three counties of the San Francisco EMA continue to be devastated by HIV – an ongoing crisis that has exacted an enormous human and financial toll on our region. According to the State of California, as of June 30, 2013, a total of **33,469** cumulative AIDS cases had been diagnosed in the EMA, representing more than **one in five** of all AIDS cases ever diagnosed in the state of California (n=**167,030**).[3] Over **22,708** persons have already died as a result of HIV infection in the EMA. As of December 31, 2012, a total of **11,582** persons were living with AIDS in the EMA's three counties while roughly the same number were estimated to be living with HIV, for an estimated total of at least **23,164** persons living with HIV infection in the three-county region (see Table in **Attachment 3**).[4] This represents an EMA-wide HIV infection incidence of **1,303.8** cases per 100,000 persons, meaning that approximately **1 in every 77 residents of the San Francisco EMA is now living with HIV.** A total of **1,004** new cases of AIDS were diagnosed in the EMA over the three-year period between January 1, 2010 and December 31, 2012 alone, representing **8.7%** of all persons living with AIDS as of that date.

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, the City of San Francisco continues to have the nation's highest per capita prevalence of cumulative AIDS cases,[5] and HIV/AIDS remains the leading cause of death in the city among all age groups, as it has been for nearly two decades.[6]** The number of persons living with AIDS in San Francisco has increased by nearly **20%** over the last decade alone - a percentage that does include more rapidly escalating non-AIDS HIV cases. Through June 30, 2103, a cumulative total of **29,428** cases of AIDS have been diagnosed in San Francisco, accounting for nearly **3%** of all AIDS cases ever identified in the US as of the end of 2011 (n=**1,138.211**) and nearly **18%** of all AIDS cases diagnosed in California (n=**167,030**), despite the fact that San Francisco County contains only **2%** of the state's population.[7] As of the end of 2012, an estimated **19,992** San Franciscans were living with AIDS or HIV, representing **86.3 %** of all persons living with HIV/AIDS in the EMA, for a staggering citywide prevalence of **2,492.0** cases of HIV per 100,000. **This means that 1 in every 40 San Francisco residents is now living with HIV disease - an astonishing concentration of HIV infection in a city with a population of just over 800,000.** As of

December 2012, the incidence of persons living with AIDS per 100,000 in San Francisco County was over **nearly ten times** that of Los Angeles County (**270.5** per 100,000) and **nearly three times** that of New York City (**820.6** per 100,000) (see Figure 1).[8] The following sections provide information on the specific demographics of the local HIV epidemic.



Race / Ethnicity: Reflecting the ethnic diversity of our EMA, the region's HIV/AIDS caseload is distributed among a wide range of ethnic groups. The majority of persons living with HIV and AIDS in the EMA are white (**60.7%**), while **13.1%** of cases are among African Americans; **18.0%** are among Latinos; and **5.6%** are among Asian / Pacific Islanders. A total of **4,551** persons of color were living with AIDS in the San Francisco EMA as of December 31, 2012, representing **39.2 %** of all PLWA, while another **4,532** persons of color were estimated to be living with HIV as of the same date (**39.1%** of all PLWH), for a total of **9.083** persons of color living with HIV/AIDS. **However, the percentage of new AIDS cases among persons of color is increasing rapidly, particularly within Latino and Asian / Pacific Islander communities.** While 39.2% of all people living with AIDS as of December 31, 2012 were persons of color, **over half** (**52.2%**) of new AIDS cases diagnosed between January 1, 2010 and December 31, 2012 were among persons of color (n=**524**). This represents the second consecutive three-year period in the EMA's history in which persons of color made up the majority of those newly diagnosed with AIDS. Latinos grew from **15.5%** to **18.0%** of all PLWHA living in the EMA between 12/31/08 and 12/31/12, while Asian / Pacific Islanders increased from **4.8%** to **5.6%** of cases over the same period. Additionally among the EMA's hard-hit transgender population, persons of color make up **79.6%** of all PLWHA, including a population that is **36.3%** African American, **30.2%** Latino, and **9.1%** Asian / Pacific Islander.

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 proportionate impact of HIV on MSM has declined over time as other populations such as women, injection drug users, and heterosexual men have been increasingly affected by the epidemic. While these groups have been impacted in our region as well, their representation as a proportion of total persons living with HIV and AIDS (PLWHA) has remained relatively low. Through December 31, 2012, fully **85.7%** of persons living with HIV/AIDS in our region were MSM (**19,857**), including **16,667** men infected with HIV through MSM contact only (**80.1%** of all PLWHA) and **3,190** MSM who also injected drugs (**1387%** of all PLWHA). This represents an **increase** from the end of 2008, when MSM made up **82.3%** of all PLWHA. By comparison, only **35.2%** of PLWHA in New York City as of December 31, 2011 were listed as infected through MSM contact.[9] Factors underlying this difference include the high proportion of gay and bisexual men living in the EMA; the large number of local long-term MSM HIV survivors; growing rates of STD infection among MSM; and relatively high local drug use rates. Other significant local transmission categories include heterosexual injection drug users (**6.9%** of PLWHA) and non-IDU heterosexuals (**4.2%**). This populations is increasing, however, with **7.0%** of new AIDS cases

between 2010 and 2012 occurring among non-drug-using heterosexuals (n=**70**) and **9.4%** occurring among non-MSM injection drug users.

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 (**91.3%**) are men. Only **6.5%** of all PLWHA in the region are women, **70.0%** of whom are women of color. Among African Americans living with HIV/AIDS, **15.2%** are women. **The San Francisco EMA contains what is by far the lowest percentage of women, infants, children, and youth (WICY) living with HIV/AIDS of any EMA or TGA in the nation, with WICY populations making up only 7.96% of PLWHA** (see Figure 3). In the city of San Francisco, the percentage is even lower, at **5.7%** of cases (n=**465**).By comparison, the next highest EMA - San Diego, CA - has a WICY percentage of **11.85%** while the TGA with the nation's highest WICY percentage - Baton Rouge, LA - stands at **42.06%**. However, there is some evidence that the proportion of women with AIDS in the EMA is increasing, with women making up **8.2%** of new AIDS cases diagnosed between January 1, 2010 and December 31, 2012. Because of their high representation within the San Francisco population, **transgender persons** also make up a significant percentage of PLWHA, with **395** transgender individuals - the vast majority of them male-to-female – estimated to be living with HIV or AIDS as of December 31, 2012, representing **2.3%** of the region's PLWHA caseload.[10]

Figure 3.
Women, Infants, Children & Youth as a Percentage of Total PLWHA Population for the 15 EMAs/TGAs in the US with the Lowest WICY Percentage as of 12/31/2010

Indianapolis, IN	22.10%
Sacramento, CA	21.04%
Las Vegas, NV	20.06%
San Antonio, TX	19.82%
Kansas City, MO	19.77%
Riverside / San Bernardino, CA	16.03%
Phoenix, AZ	15.86%
San Jose, CA	14.81%
Santa Ana CA	14.78%
Los Angeles, CA	14.64%
Portland, OR	13.29%
Seattle, WA	13.05%
Denver, CO	11.91%
San Diego, CA	11.85%
San Francisco, CA	**7.96%**

Current Age: **A rapidly growing 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 the region's hard-fought success in bringing persons with HIV into care and prolonging the length of their lives. As of December 31, 2012, **nearly half of all persons living with HIV/AIDS in the EMA** (**48.5%**) are age 50 or older, including **589** PLWHA age 70 and older and at least **63** PLWHA age 80 or older. **Persons 50 and older now make up nearly 3 out of every 5 persons living with AIDS in our EMA, constituting 59.7% of the PLWA population as of the end of 2012** (n=**6,916**)**.** Between December 2006 and December 2012 alone, the number of persons 50 and over living with AIDS increased by **51.1%** within the EMA (from **39.5%**), while the overall number of PLWA as a whole increased by only **4.5%** (from **11,088**). This growing aging population creates dramatic challenges for the local HIV service system, including the need to develop systems to coordinate and integrate HIV and geriatric care and to plan for long-term impacts of HIV drug therapies. The largest proportion of persons living with HIV and AIDS in the EMA remain those between the ages of 40 and 49, who make up **33.0%** of the combined PLWHA population (n=**7,654**). But persons between the ages of 50 and 59 are close behind, making up **32.1%** of all PLWHA in the EMA (n=**7,441**). A total of **298** young people between the ages of 13 and 24 are estimated to be living with HIV/AIDS in the EMA, constituting **1.3%** of the PLWHA population. However, young people ages 13-24 make up **5.6%** of all new AIDS

cases diagnosed between January 1, 2010 and December 31, 2012, pointing to a growing HIV incidence within this population. Only **1** child age 12 and under is living with HIV or AIDS in the EMA, and **no** new AIDS cases were diagnosed among this group between January 1, 2010 and December 31, 2012.

The chart below summarizes the total number of new AIDS cases reported within the past three calendar years from 2010 through 2012.

Number of new AIDS Cases Reported in San Francisco EMA - 2010 - 2012		
CY 2010	**CY 2011**	**CY 2012**
367	**354**	**296**

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 **4.3%** of EMA residents are African American, they make up **13.1%** of combined PLWHA populations in the San Francisco EMA are African American, meaning that **more than three times** the percentage of African Americans are infected with HIV as their proportion in the general population. And while **60.7%** of all PLWHA are white, only **46.7%** of EMA residents are white. By contrast, Asian/Pacific Islanders make up **26.7%** of the EMA's total population but comprise **5.6%** of PLWHA cases while Latinos constitute **18.0%** of PLWHA but make up **19.3%** of EMA residents. However, new HIV cases will soon create a disproportionate impact among Latinos as well, with **21.6%** of newly diagnosed AIDS cases occurring among Latinos between January 1, 2010 and December 31, 2012.

Homeless and **formerly incarcerated individuals** are also significantly over-represented among persons living with HIV and AIDS in our region. While the combined annual EMA-Wide Homelessness Rate is estimated at **1,571** per 100,000, including an estimated **13,500** chronic homeless and another **13,140** individuals who become homeless at some point each year,[11] the combined annual EMA-Wide homelessness rate among persons living with HIV and AIDS is estimated at **7,999** per 100,000[12] - a rate **more than four times** the rate of homeless among the general population. Meanwhile, according to the Center on Juvenile and Criminal Justice, a total of **18,857** EMA residents were imprisoned at some point during calendar year 2011,[13] while more than **43,000** annual bookings take place in the three-county region.[14] While available reports do not reveal how many of these arrested are among **unduplicated** persons, a conservative estimate based on prevailing recidivism rates would be **17,500** unduplicated individuals arrested and incarcerated each year in the EMA, for an estimated total of **50,000** individuals spending time in incarceration facilities over the past three years - a rate of **2,815** per 100,000. According to Ryan White service data for **Forensic AIDS Project** – the local Center of Excellence serving recently incarcerated persons - a total of at least **623** unduplicated individuals incarcerated in the San Francisco County jail were HIV-positive and receiving Ryan White services between July 1, 2009 and June 30, 2012 representing **8.1%** of the city's total Ryan White caseload of **7,660** clients as of February 28, 2012, for a three-year incarceration rate of **8,133** per 100,000 – a rate **more than three times** that of the general population.

The epidemic's most disproportionate impact remains among **gay and bisexual men**. While reliable estimates are hard to come by, the most recent estimates indicate that at least **63,577** gay-identified MSM live in the San Francisco EMA,[15] and an estimated **19,857** of them were living with HIV as of December 31, 2012. **This means that a startling 31.2% of all gay-**

identified MSM in the San Francisco EMA may already be HIV-infected, setting the stage for a continuing health crisis that will impact the future of our region for decades to come. By contrast, less than **0.4%** of heterosexual men are estimated to be HIV-infected in the San Francisco EMA.

Underrepresented Populations in the Ryan White System: Compared to their proportion of HIV/AIDS cases, **women, persons of color, heterosexuals,** and **transgender people** are **over-represented** in the local Ryan White-funded system, Meanwhile, **whites, men,** and **MSM** are **underrepresented** due largely to higher average incomes and higher rates of private insurance which reduce their need to rely on Ryan White-funded care. For example, while women make up only **6.5%** of all PLWHA in the EMA, they comprise **11.8%** of all Ryan White clients as of February 28, 2013 (n=**863**). Meanwhile, while whites make up **60.7%** of all PLWHA in the EMA, they comprise only **44.6%** of Ryan White clients as of the same date (n=**3,254**). Ryan White clinics provide primary medical care to a population that is disproportionately made up of persons of color, women, persons with low incomes, the homeless, heterosexuals, and injection drug users. Additionally, local Part D programs primarily serve young people and women, while Part C programs such as those operated by the San Francisco Clinic Consortium serve the full spectrum of clients, including the homeless, persons of color, women, and gay/bisexual men. Fully **23.7%** of Ryan White clients in the San Francisco EMA are African American (n=**1,730**) despite the fact that they comprise **13.1%** of all persons with HIV/AIDS in the EMA. At the same time, San Francisco's seven **Centers of Excellence** which focus on underserved and hard-to-reach populations serve a population that is **30.6%** African American.[16] Women, representing **6.5%** of the total PLWHA population, make up **21.7%** of all Centers of Excellence clients. Transgendered people make up **3.0%** of persons served through the Ryan White system and **5.4%** of persons served through Centers of Excellence while making up **2.1%** of all persons living with HIV and AIDS in the EMA. **All of these statistics highlight the progress the San Francisco EMA has made in reaching and bringing into consistent care the most impoverished and highly underserved HIV-infected residents of the region.**

EMA Service Gaps: According to the recently completed 2011-2012 Unmet Need Framework (see Attachment 6), an estimated **2,502** HIV-aware individuals in the San Francisco EMA were **not** receiving HIV primary care as of June 30, 2012, representing **12%** of the region's total HIV-aware population (n=**20,791**). This is a significant reduction from the 2009-2011 estimate, in which **2,898 (14%)** HIV-aware individuals were estimated to not be receiving HIV primary care, and a dramatic reduction from FY 2008-2009, when **5,205 (23%)** were estimated to be out of care. **These reductions are reflective of our ongoing success in identifying, referring, and linking new HIV-positive persons to care, despite continually increasing number of persons living with HIV and AIDS in our region, and the commensurate growing cost of caring for these individuals.** Between March 1, 2012 and February 28, 2013, at least **7,290** individuals were receiving Ryan White services in the EMA, representing an impressive **39.9%** of the region's combined PLWHA population in care (n=**18,289**) and **31.5%** of the EMA's total PLWHA population (n=**23,164**).

In 2008, the San Francisco EMA commissioned and completed a **Comprehensive HIV Health Services Needs Assessment** (the last comprehensive needs assessment conducted by the Planning Council in our region), which included in-depth client surveys completed by **248** PLWHA in all three counties and a series of **4** population-specific focus groups involving monolingual Spanish-speaking persons; persons age 55 and older; Marin County residents; and formerly incarcerated individuals.[17] The Needs Assessment revealed that the local system of care was **extremely successful** in meeting HRSA core service needs among HIV-infected persons

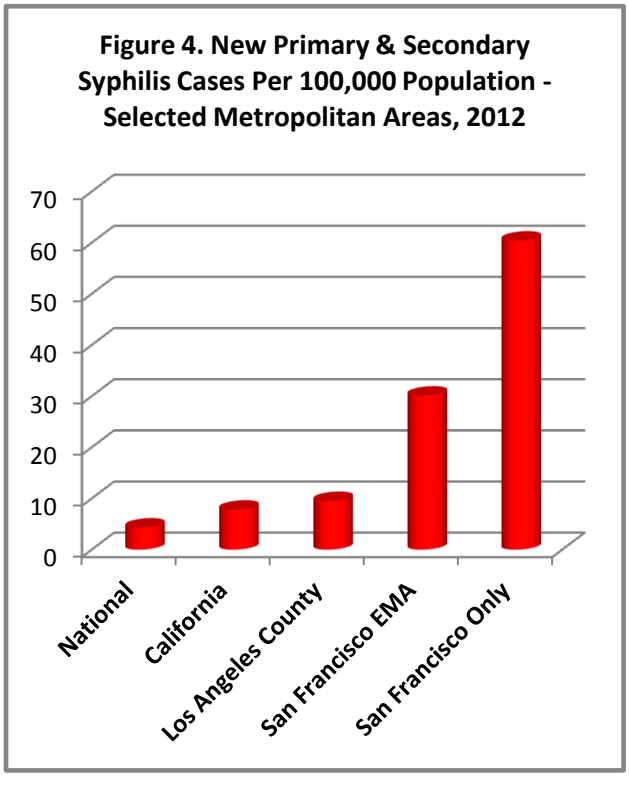
who have low incomes, with fully **95%** of survey respondents reporting that their last health care visit for HIV/AIDS had been within the past six months. While the majority of needs assessment respondents stated that they were able to access needed care services, challenges and barriers to health and supportive services that respondents "always" or "sometimes" experience included: a) **transportation** (**12.7%** always / **30.5%** sometimes); b) **service hours** (**6.8%** always / **35.0%** sometimes); c) **cultural sensitivity** (**3.8%** always / **15.3%** sometimes); and d) **language** (**3.0%** always / **9.7%** sometimes). In regard to housing, **21%** of survey respondents met the criteria for being **homeless** - including **4%** living on the streets or in a car - while **12%** of respondents did not have health coverage of any kind.

1.B) Impact of Co-Morbidities and Medicaid Funding on the Cost and Complexity of Providing Care

1.B.1) Quantitative Evidence on Co-Morbidities - See **Table** in **Attachment 4**

1.B.2) Narrative on Cost and Complexity of Providing Care

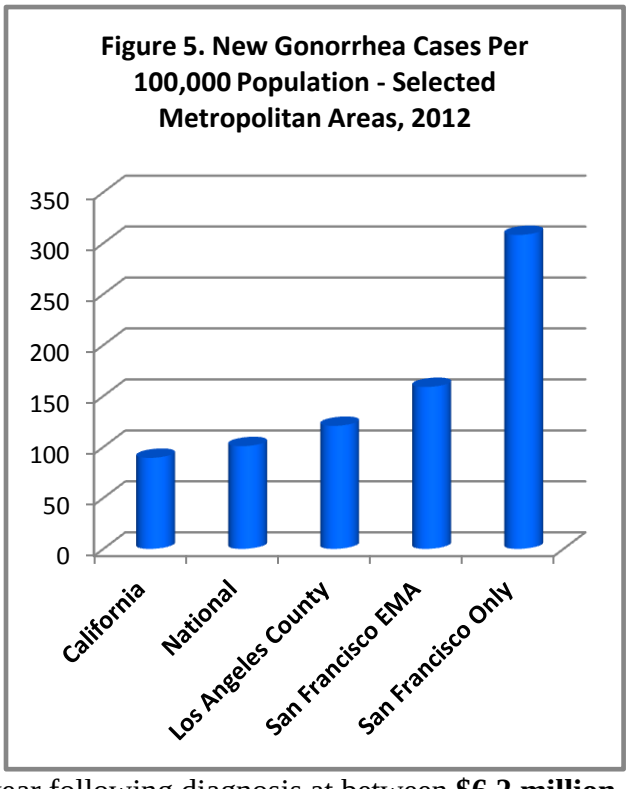
Sexually Transmitted Infection (STI) Rates: The growing crisis of **sexually transmitted infections** is of significant concern for the future of the HIV epidemic in our region**.** In terms of **syphilis,** for example, the San Francisco EMA continues to confront a **major epidemic** that has been escalating for the past half decade, rising **more than 500%** since 2000. In 2012, a total of **536** new primary and secondary syphilis cases were diagnosed in the EMA, representing a **134% increase** over the **229** cases reported just five years earlier in 2007.[18] The combined EMA-wide syphilis rate of **30.1** per 100,000 in 2012 was nearly **four times** the 2012 statewide rate of **7.8.** Within the City of San Francisco alone, a total of **486** new syphilis cases were reported in 2012 for a shocking incidence rate of **60.4** cases per 100,000, a rate **nearly eight times higher** than the statewide rate and **more than ten times higher** than the national syphilis rate of **4.3** cases per 100,000 in 2011 (see Figure 4). **San Francisco County has by far the largest syphilis infection rate of any county in California,** nearly **five times** the rate of the next highest county, San Joaquin County (**10.7** per 100,000) and nearly **six times** that of Los Angeles County (**9.5** per 100,000).[19]



The EMA is also experiencing a significant **gonorrhea** epidemic. A total of **2,827** new gonorrhea cases were identified in the San Francisco EMA in 2012, for an EMA-wide incidence of **158.9** cases per 100,000, a rate that is nearly **100% higher** the 2012 California rate of **89.3** cases per 100,000. [20] [21] The city of San Francisco's 2012 gonorrhea incidence of **308.1** cases per 100,000 (n=**2,480**) is **nearly three times** the national rate of **100.8** cases per 100,000 and **more than three times higher** than the rate for the State of California as a whole, and is again by far the highest rate of any county in California, with the next highest county – Sacramento County - having a case rate that is **half** that of San Francisco at **149.7** per 100,000 (see Figure 5).[22]

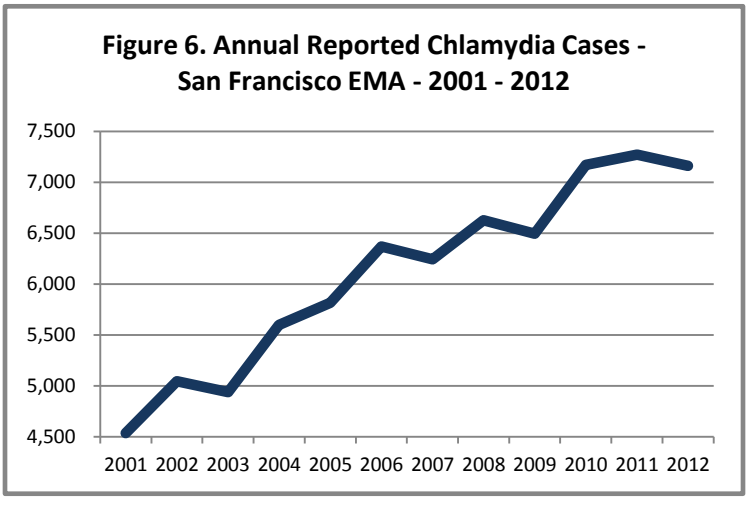
The San Francisco EMA's **Chlamydia**

epidemic also continues to rise precipitously. A total of **7,160** new cases of Chlamydia were diagnosed in the San Francisco EMA in 2012. This represents a **23.1% increase** over the **5,816** cases diagnosed in 2005 and a **57.9% increase** since 2001 (see Figure 5).[23] The 2012 EMA-wide Chlamydia incidence stood at **402.5** per 100,000, while the rate for the City of San Francisco was **605.3** cases per 100,000. By comparison, the 2012 incidence for California was **448.9** cases per 100,000 while the national rate was **426.0**.[24]



The cost of treating STIs adds significantly to the cost of HIV care in the San Francisco EMA. According to a study which estimated the direct medical cost of STIs among American youth, the total annual cost of the **9 million** new STI cases occurring among 15-24 year olds totaled **$6.5 billion** in the US, at a per capita cost of **$7,220 per person.**[25] Lissovoy, et al. estimated 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.[26] A study published in the *American Journal of Public Health* estimated that 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.**[27] Such studies suggest that the total cost of treating new STIs in the SF EMA may be as high as **$6.9 million** per year, including an estimated **$2.9 million** to treat STIs among persons with HIV, with another **$7.5 million** in annual costs potentially resulting from the need to treat persons infected with HIV as a result of transmission facilitated through other STIs.[28]

<u>Housing and Homelessness:</u> 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; 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, with one study reporting HIV risk factors among **69%** of homeless persons.[29]



Because of the prohibitively high cost of housing in the San Francisco EMA and the shortage of affordable rental units, the problem of homelessness has reached crisis proportions, creating formidable challenges

for organizations seeking to serve HIV-infected populations. According to the National Low Income Housing Coalition's *Out of Reach 2012* report, Marin, San Francisco, and San Mateo Counties – the three counties that make up the San Francisco EMA – **are tied with one another as the three least affordable counties in the nation** in terms of the minimum hourly wage needed to rent an average two-bedroom apartment, which currently stands at **$36.63 per hour** (see Figure 7).[30] Meanwhile, as of 2012, the City of San Francisco has the **highest HUD-established Fair Market Rental rate in the nation** at $1,795 per month for a 2-bedroom apartment, which represents the amount needed to "pay the gross rent of privately owned, decent, and safe rental housing of a modest nature".[31]

Figure 7.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs, 2012

County	Hourly Wage Needed to Rent a Two-Bedroom Apartment at HUD Fair Market Rents
San Francisco County, CA	$ 36.63
Marin County, CA	$ 36.63
San Mateo County, CA	$ 36.63
Nantucket County, MA	$ 34.60
Honolulu County, HI	$ 33.98
Nassau County, NY	$ 32.35
Suffolk County, NY	$ 32.35
Orange County, CA	$ 31.77
Santa Clara County, CA	$ 31.21
Westchester County, NY	$ 30.38

On January 24, 2013, the City of San Francisco conducted its bi-annual 24-hour homeless count which identified a total of **6,436** homeless men and women living on the streets or in jails, shelters, rehabilitation centers, or other emergency facilities, a slight decrease from the 2011 total of **6,455**.[32] At the same time, the 2013 San Mateo County Homeless Census and Survey identified a total of **2,281** homeless people on the night of January 24, 2013, including **1,229** unsheltered homeless people living on streets and **982** sheltered homeless people[33] while recent estimates place the number of homeless people in Marin County from as low as **1,770** to as high as **6,000**.[34] The City of San Francisco also serves an additional **3,000 - 7,000** temporarily homeless individuals per year, which means that - with anywhere from **9,500** to **13,500** homeless per year - the city has the **second highest per capita homelessness rate of any city in the U.S**.[35] 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.[36] Aging augments the progression of chronic diseases related to homelessness, including high rates of diabetes and hypertension, and complicates the problem of providing care to these groups. It is estimated that **23,540** individuals experience homelessness at some point during the year in the EMA, including an estimated **10,500** chronically homeless individuals and **13,040** 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[37] to an astounding **41%** among marginally housed adult MSM.[38] 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 young people - estimated HIV prevalence ranges from **29%** among young homeless gay and bisexual males[39] to **68%** among gay and bisexual male teens who enter homeless youth centers.[40] **HIV disease 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 9% in 2006 to 14% in 2010, a more than 150% increase.**[41] Persons who were

homeless at the time of their HIV diagnosis over this period were more likely to be women, transfemale, African American, and IDU.[42]

The burden of **costs** that homelessness places on the local system of care is difficult to calculate, but adds significantly to the price of HIV/AIDS care. 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.[43] Meanwhile, a two-year University of Texas survey of homeless individuals found that the public cost of caring for the homeless averaged **$14,480** per person per year, primarily for overnight jail stays.[44] Overall, SF DPH estimates that the total costs of homelessness add at least an additional **$16.2 million** to the cost of care for HIV-positive individuals within the EMA – costs that do not take into account the higher rates of HIV infection among homeless populations.[45]

Insurance Coverage: The advent of health care reform through the Affordable Care Act (ACA) promises significant, positive change in regard to the number and proportion of low-income persons with HIV in our region who will benefit from affordable and accessible health insurance coverage. California is now in the process of implementing its "Bridge to Reform" Section 1115 Medicaid Demonstration Waiver program whose **Low Income Health Insurance Program (LIHP)** is expected to extend Medicaid coverage to approximately **1.4 million** of the nearly 7 million uninsured in California by 2016, a **10%** increase over current levels. However, while creating important change, the problem of lack of insurance continues to be a major barrier to care at the time of this writing, and the future of coverage is uncertain for many populations. According to the most recent data from the UCLA Center for Health Policy Research, at the end 2011 fully **12.4%** of San Francisco EMA residents under the age of 65 were without **any** form of insurance coverage - including Medicaid - for a total of at least **219,466** uninsured individuals under age 65 in our region.[46] This includes an estimated **16.4%** uninsured in San Francisco; **12.8%** uninsured in San Mateo County; and **9.9%** uninsured in Marin County, for an EMA-wide uninsured incidence of **12,400** among persons under age 65.

The lack of health insurance places extreme financial burden on the system, particularly in the San Francisco EMA, which has extremely high medical costs. In addition, because of the current financial crisis, the numbers of persons who have lost private insurance as a result of unemployment or reduced employment based health insurance benefits has dramatically increased the number of uninsured persons in the State over the past two years. While approximately **half** of San Francisco Ryan White system clients are covered by Medicaid, roughly **one-quarter** lack **any** form of insurance coverage. At the same time, for those persons with HIV not in care or unaware of their HIV status, the uninsured rate is believed to be much higher than the general population as many HIV-infected people in the EMA are poor, not in care, and/or have not yet applied for Medicaid. SF DPH estimates that the **cost** to the system of serving uninsured and indigent populations living with HIV is at least **$91.5 million** annually, based on an average **25.1%** uninsured rate among PLWHA in care (n=**4,576)** at an estimated annual avg. 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. According to the 2010 Census, the average percentage of persons living at or below federal poverty level stands at **9.2%** for the entire San Francisco EMA. Using this data, SF DPH projects that at least **490,201** individuals in the San Francisco EMA are living at or below 300% of Federal Poverty Level, which translates to **27.6%** of the overall EMA population lacking resources to cover all but the most basic expenses. **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 the San Francisco AIDS Regional Information and Evaluation System (ARIES),the SF EMA's client-level data system, it is estimated that at least **68.9%** of all persons living with HIV/ AIDS in the San Francisco EMA (n=**15,960**) are living at or below 300% of the 2013 Federal Poverty Level (FPL) including persons in impoverished households. **100%** of Ryan White-funded clients live at or below 300% of poverty.[47] ARIES data reveals that **over half** (**55.2%**) of active Ryan White clients in the San Francisco are currently living at or below 100% of FPL while another **30.5%** are living between 101% and 200% of FPL. HIV-infected persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **$69 million** in Part A and non-Part A HIV-related expenditures in the San Francisco EMA each year.[48]

Trends in Service and Fiscal Resources: The ongoing California budget crisis resulted in severe and significant reductions in State resources for health care services between 2009 and 2012, including total cumulative cuts of over **$2 billion** in basic health services, which, among other impacts resulted in the loss of dental coverage for low-income Californians. The State's entire HIV prevention budget was eliminated during this period, resulting in a loss of at least **$59.1 million per year** to support basic community-based HIV prevention efforts. In the San Francisco EMA specifically, direct effects of the State budget crisis included the closing of the University of the Pacific Dental Clinic in 2009; the termination of van service for medical visits for disables PLWHA in San Francisco, also in 2009; termination of the HIV Volunteer Services Program in Marin County in 2010; and the closing of Tenderloin Health Services in 2012. While the advent of expanded health coverage through ACA has already begun to be a major boon to the region, expanded coverage in itself cannot directly restore the crucial service and support programs for low-income PLWHA that were lost in the recent budget crisis.

1.B.3) Impact of Formerly Incarcerated Individuals

The San Francisco EMA HIV care system provides services to a large number of formerly incarcerated individuals whose significant needs pose additional challenges. As noted above, the California Department of Corrections reports that an average total of **17,500** unduplicated individuals are estimated to be arrested and incarcerated each year in the EMA, while a minimum of **65,000** annual bookings take place in the three-county region. As noted above, data for Forensic AIDS Project reveals that at least **623** unduplicated individuals incarcerated in the San Francisco County jail were HIV-positive and receiving Ryan White services between July 1, 2010 and June 30, 2012, representing **8.1%** of the city's total Ryan White caseload of **7,290** clients as of February 28, 2013, for a three-year incarceration rate of **8,545** per 100,000 – a rate **more than three times** that of the general population. Transitions between the community and incarceration often greatly impact an individual's ability to access and remain in HIV care and treatment, and to stabilize life circumstances that promote wellness.

The San Francisco EMA is also home to **San Quentin State Prison**, California's oldest and largest prison. Opened in 1852, the prison houses an average daily population of **5,222** inmates in facilities originally designed to house 3,317 individuals. The prison also serves as the identification point for a large number of persons with HIV, many of whom are paroled to the Bay Area and seek HIV services following release. Over a three year period from January 1, 2010 through December 31, 2012 a total of **7** new AIDS cases **were** diagnosed at San Quentin Prison, while a total population of **346** persons living with HIV and AIDS were being housed at the prison as of December 31, 2012. More than **half** of these inmates (**62.1%**) were infected through injection drug use, including MSM injection drug users, as compared to **20.7%** of all persons living with HIV/AIDS in the EMA. **African Americans** are highly overrepresented

among the San Quentin HIV population, representing **49.4%** of all PLWHA at the facility as of 12/31/12.

An analysis of epidemiological and client data reveals a range of factors that are strongly associated with significantly increased cost and complexity of care for formerly incarcerated populations with HIV in the Bay Area. For example, of the **623** HIV-positive individuals served by Forensic AIDS Project and released from SF jails in the three years through June 30, 2012, **12.7%** were **women** – **double** the percentage of women living with HIV/AIDS in the EMA (**6.5%**) – and **4.7%** were **transgender persons – more than double** their representation among the EMA's total PLWHA population (**2.2%**). Reflecting high rates of injection drug use among incarcerated populations, **27.9%** of persons with HIV in the SF jail system had been infected through injection drug use alone, as compared to **6.9%** of the overall PLWHA population, while MSM / IDU cases accounted for **18.6%** of jail populations, versus **13.8%** of all PLWHA. These findings are mirrored in a study of young injectors under age 30 in San Francisco, which found that **86%** had a lifetime history of incarceration; **56%** had been incarcerated in the past year; and **42%** were infected with hepatitis C – a critical marker of potential HIV infection.[49] Equally alarming is the over-representation by **African Americans** among formerly incarcerated persons with HIV in SF, who account for **47.5%** of all PLWHA diagnosed with HIV or provided with HIV care in San Francisco jails, despite making up **13.5%** of the total PLWHA population.

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

The precise burden of **costs** related to the high rates of recent incarceration among PLWHA populations in the San Francisco EMA is difficult to calculate. However, demographic characteristics of this population – including a higher percentage of women and transgender persons with low incomes; greater representation by African Americans with low incomes; and higher rates of injection drug use – point to indicators of severe need requiring specialized support and assistance that significantly increase our region's cost of HIV care. Annual services by Forensic AIDS Project, for example, are currently budgeted at **$346,558** per year, a figure that includes only immediate post-release care and service linkage. Additional costs related to higher rates of HIV infection related to incarceration itself, coupled with long-term costs of care and treatment for individuals with low incomes and persons with issues of substance use, may total at least **$1.23 million** per year in additional direct incarceration-related HIV expenditures for the San Francisco EMA.[50]

1.C) Impact of Part A Funding: Funding Mechanisms

1.C.1) Report on Availability of Other Public Funding: See **Attachment 5**.

1.C.2) Coordination of Services and Funding Streams

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 Ryan White Part A funds are coordinated across all applicable funding streams in the region. The

Planning Council also reviews annual service category summaries that include a detailed listing of all Ryan White and non-Ryan White funding sources for 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 ensures that services are coordinated to maximize the number and accessibility of services, while seeking every possible alternate source of funding apart from Part A to support HIV care.

The most important complementary funding stream to support HIV care for populations with low incomes is the **Medicaid** system, or **Medi-Cal**, as the system is known in California. Medi-Cal is an indispensable link in the chain of support for persons with low-incomes and HIV in the San Francisco EMA. Based on a report from California Medi-Cal Office, the SF EMA projects that a total of **$99,909,988** in HIV-specific Medi-Cal expenditures were incurred across the EMA's three counties in calendar year 2012. **Just under one-half (46.0%)** of HIV Medi-Cal expenditures in the EMA were projected to be for **HIV-related medications** (**$45,932,154**); another **8.7%** (**$8,706,066**) were for **inpatient care;** and **18.2%** (**$18,205,732**) were for **intensive and skilled nursing care.** The remaining **27.1%** was dispersed among other categories. A total of at least **5,339** unduplicated HIV-positive individuals were Medi-Cal recipients in 2012. The SF HIV Health Services Planning Council examines changes in Medi-Cal data each year and considers this information in allocating Part A primary medical care funding.

Other significant non-Ryan White funding streams which affect the allocation of Part A resources in the San Francisco EMA include the following:

- The **AIDS Drug Assistance Program (ADAP)** provides a major source of income for HIV care in California, supporting the costs of a diverse formulary for tens of thousands of low-income California residents. According to NASTAD's 2013 National ADAP Monitoring Report, ADAP drug purchase expenditures in California for fiscal year 2012-2013 totaled **$444,713,103**, by far the largest ADAP budget in the nation and **38% higher** than the next highest state, New York, at $321,922,076.[51] At the same time, California's state contribution to the program totaled **$33,135,058** also by far the largest contribution by any state in the nation, making up **12.1%** of combined state ADAP contributions nationally. **However, this contribution represents a 66% reduction from State ADAP funding levels in FY 2008, reflecting the devastating impact of the State's budget crisis of support for basic HIV medications.** A total of **34,435** Californians were enrolled in ADAP as of December 2012 as compared to 20.454 for the state of New York, the next highest state. While California has continually demonstrated its unwavering support for ADAP – most recently in the 2011-2012 State budget – the future of ADAP is far from certain. At the same time, however, anticipated expanded Medi-Cal support for drug reimbursement through the ACA may significantly relieve State pressure in regard to the burden of State ADAP support.
- Veterans in the EMA are able to access care at **three Veterans Administration (VA)** clinics in the EMA: the Infectious Diseases Clinic at the San Francisco VA Medical Center, offering primary medical care to PLWHA along with access to clinical trials and research; the VA outpatient clinic in the South of Market area in San Francisco; and the Palo Alto VA Center located just outside the EMA, with a satellite clinic in Menlo Park in San Mateo County which is co-located with a public Part A-funded clinic.
- **Housing Opportunities for Persons with AIDS (HOPWA)** services are coordinated through the HOPWA Loan Committee, which includes two Planning Council representatives. For FY 2012-2013, the total HOPWA allocation for the San Francisco EMA totals **$9,775,600,** including **$8,564,000** for San Francisco County; **$873,900** for San Mateo County; and **$337,700** for Marin County.

- The Grantee works closely with the **San Francisco Redevelopment Agency** to coordinate housing access for Ryan White Part A-funded clients.
- Other state and local social services programs such as **General Assistance** and **vocational rehabilitation programs** are used by PLWHA in the EMA. General Assistance provides a very small amount of money per month for the few clients who qualify which is less than the rental cost for an average single room occupancy (SRO) hotel room. Vocational services including counseling, training, and job placement are provided directly to PLWHA 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 combining 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, increased funds available for substance abuse treatment in the EMA. However, funding for Proposition 36 was eliminated by the Governor in California's 2009 budget, and local governments cannot fill this gap. The EMA has therefore lost a major source of support for substance abuse treatment services. California also receives HIV set-aside funds from **SAMHSA**, which are primarily used to provide HIV counseling and testing within substance abuse treatment programs.

Coordination with Other Ryan White Act Programs: The San Francisco EMA is dedicated to ensuring the integration and coordination of **all** sources of Ryan White funding in the region. The Health Services Planning Council prioritizes the use of Ryan White funds for services that are not adequately funded through other reimbursement streams to ensure that Part A funds are the funding source of last resort. During each year's priority setting and allocation process, the Grantee produces detailed fact sheets on each service category that include a listing of **all** other funding streams available for that category, including Part B, C, D, and F programs, ADAP, and MAI funding. The Planning Council also assists in the planning for Part B-funded services. The Planning Council works with other local planning groups such as the HIV Prevention Planning Council and Long Term Care Coordinating Council to coordinate services and eliminate duplication. The figure below details complementary Ryan White contributions in the San Francisco EMA during the most recent 12-month contract period (see Figure 8).

Figure 8. Table of Complementary Ryan White Funding – San Francisco EMA
Most Recently Completed 12-Month Funding Cycles

Local Jurisdictions	Ryan White Funding Categories & Amounts					H.U.D.
	Part A MAI	Part B	Part B MAI	Part C	Part D	HOPWA
San Francisco Co.	$ 710,899	$ 2,240,811	$ 87,399	$ 1,065,719	$ 522,553	$ 8,564,000
San Mateo Co.		$ 264,489	$ 26,000			$ 873,900
Marin Co.		$ 124,250	$ 26,000			$ 337,700
TOTAL	$ 710,899	$ 2,629,550	$ 139,399	$ 1,065,719	$522,553	$ 9,775,600

1.D) Assessment of Populations with Emerging Needs

As a highly diverse and complex region with an expanding HIV caseload, the San Francisco EMA is home to many populations with emerging needs, including women, youth, and transgender people; members of distinct ethnic, cultural, and linguistic groups; homeless and formerly incarcerated persons; and members of diverse social and behavioral communities. These groups require specialized interventions to link and retain them in care; meet their service

needs; and empower them to become effective self-care advocates. **The challenge of effectively meeting the needs of emerging populations in the context of declining resources remains one of the most daunting issues facing the local system of care.** This year, SF DPH has selected the following **six** emerging populations that face evolving needs for specialized HIV care, each of which is described briefly below: **1)** Persons with HIV 50 Years of Age and Older; **2)** Transgender Persons; **3)** Men of color who have sex with men; **4)** Homeless individuals; **5)** African Americans; and **6)** Latinos. All of these groups have growing incidences of HIV infection resulting in increased costs to the local system of care.

Emerging Population # 1: Persons With HIV 50 Years of Age and Older: In part because it was one of the first regions hard hit by the HIV epidemic and in part because of its success in ensuring that a large proportion of persons with HIV have access to the high quality treatments and therapies, the HIV-infected population of the San Francisco EMA continues to age dramatically, at levels beyond which could have been imagined in the first decade of the epidemic. **As of December 31, 2012, just under half of all persons estimated to living with HIV and AIDS in the San Francisco EMA (48.5%) were 50 and older (11,230 persons).** This represents a **14.7% increase** over the 9,787 PLWHA 50 and older only two years ago. **At the same time, persons 50 and older make up nearly 3 out of every 5 persons living with AIDS in the EMA (6,916 out of 11,582 persons / 59.7%)**.

An analysis conducted for this application of the **9,985** persons age 50 and above **confirmed** to be living with HIV/AIDS in the San Francisco EMA as of December 31, 2011 (see Figure 9) reveals many significant facts about this population, including the fact that there **over 60%** of all 50 and older PLWHA (**61.3%**) have been living with HIV for **16 or more years** (n=**6,121**) and that nearly **one-third** (**30.1%**) have been living with HIV for **two decades or more** (n=**3,008**). These percentages speak both to the success of combination HIV therapies and the success of the San Francisco EMA in retaining persons with HIV in long-term treatment with high-level medical care and social services. The 50 and over population in San Francisco also contains a slightly higher percentage of African Americans than in the

Figure 9.
Persons Living with HIV/AIDS Age 50 and Above in the San Francisco EMA as of 12/31/12 (Confirmed Cases Only)

Demographic Categories	Number	Percent
Gender		
Male	9.235	92.5%
Female	613	6.1%
Transgender	137	1.4%
Ethnicity		
White	6,804	68.1%
African American	1,463	14.7%
Latino	1,219	12.2%
Asian / Pacific Islander	352	3.5%
Other / Unknown	147	1.5%
Transmission Categories		
MSM	7,258	72.7%
Injection Drug Users	868	8.7%
MSM Injection Drug Users	1,2620	12.6%
Non-IDU Heterosexuals	346	3.5%
Other / Unidentified	251	2.5%
Time Since 1st HIV Diagnosis		
0 - 2 Years	246	2.5%
3 - 5 Years	437	4.4%
6 - 10 Years	1,169	11.7%
11 - 15 Years	2,012	20.2%
16 - 20 Years	3,113	31.2%
More Than 20 Years	3,008	30.1%
TOTAL	**9,985**	**100.0%**

PLWHA population as a whole (**14.7%** vs. **13.1%**), along with a higher proportion of non-MSM injection drug users (**8.7%** vs. **6.9%**).

Because HIV medications are still relatively new, it is not yet known either what the long-term effects of HAART will be on older persons with HIV or how traditional health issues related to aging and geriatric health may interact with or complicate HIV treatment and care. Aging populations will certainly present challenges to the health care system in terms of devising new strategies for providing integrated HIV and geriatric care, and for meeting the long-term needs of clients with increasingly complex needs. At the same time as a result of previous employment, many older long-term survivors living with HIV/AIDS who have had the advantage of long-term disability policies will lose those benefits immediately upon reaching Social Security retirement age and may find themselves immediately in poverty, a problem with which the current system is unprepared to deal . The annual **cost** of providing HIV-related services to persons over 50 years of age within the SF EMA is estimated to be as high as **$179,680,000**.[52]

Figure 10.
MTF Transgender Persons Living with HIV/AIDS in San Francisco County as of 12/31/12
(Confirmed Cases Only)

Demographic Categories	Number	Percent
Current Age		
13- 24 Years	10	2.3%
25 - 49 Years	280	65.6%
Age 50 and Above	137	32.1%
Ethnicity		
White	87	20.4%
African American	155	36.3%
Latino	129	30.2%
Asian / Pacific Islander	39	9.1%
Other / Unknown	17	4.0%
Transmission Categories		
MSM	234	54.8%
Injection Drug Users	5	1.2%
MSM Injection Drug Users	181	42.4%
Non-IDU Heterosexuals	6	1.4%
Other / Unidentified	2	0.2%
TOTAL	**427**	**100.0%**

Emerging Population # 2: Transgender Persons: Transgender persons are traditionally defined as those whose gender identity, expression, or behavior is not traditionally associated with their birth sex. Some transgender individuals experience gender identity as being incongruent with their anatomical sex and may seek some degree of gender confirmation surgery, take hormones, or undergo other cosmetic procedures. Others may pursue gender expression (whether masculine or feminine) through external self-presentation and behaviors. Key HIV risk behaviors among transgender persons include **multiple sex partners**, **irregular condom use**, and **unsafe injection practices** stemming both from drug use and from the injection of hormones and silicone.[53]

Because of the region's traditional openness to diverse lifestyles, many transgender individuals move to the San Francisco EMA seeking greater acceptance and an expanded sense of community. According to Clements, at least **5,000** transgender persons call the Bay Area home, although precise statistics are not available.[54] What is not in question, however, is the epidemic's growing impact on these populations. As of December 31, 2012, an estimated **492** transgender persons were living with HIV and AIDS in the San Francisco EMA, although actual numbers are probably much higher, with some studies indicating that HIV infection rates may be as high as **23.8%** among this population**,** which in San Francisco would mean that at least **1,200** transgender persons may already be living with HIV.[55] Figure 10 provides a demographic breakdown of **confirmed** male-to-female (MTF) transgender PLWHA in San Francisco County as of 12/31/12 and offers some fascinating insights into the complexity of this population. One

striking fact relates to the **cultural diversity** of transgender PLWHA, with the largest infected ethnic groups being **African Americans (36.3%)** and **Latinos (30.2%).** Together these groups make up **66.5%** of transgender PLWHA but only **31.1%** of all PLWHA in the EMA. By contrast, while whites make up **60.7%** of all estimated PLWHA in the EMA, they comprise only **20.4%** of transgender PLWHA. These figures speak to the high levels of **poverty** among transgender women in the EMA. The category of "MSM" is challenging in regard to this population because transgender women who engage in sex with men are not technically MSM. Nevertheless, was is most striking is the fact that fully **42.4%** of transgender PLWHA were infected through combined MSM / IDU behavior, versus only **13.8%** for the EMA as a whole. This percentage reflects both the widespread use of needles to inject hormones and the high level of injection-based drug use among this population.

Because of culturally-defined dichotomous gender roles, transgender persons face **widespread stigma and discrimination** which can create significant barriers to HIV care. Transgender-related stigma is associated with **lower self-esteem**, **increased likelihood of substance abuse** and a high prevalence of **survival sex work**, particularly among MTFs.[56] **Social marginalization** resulting from discrimination can result in the denial of educational, employment, and housing opportunities, factors that can reduce utilization of health services by forcing transgender persons to focus on **survival issues**. Transgender persons also frequently lack access to health services due to low socioeconomic status, lack of insurance, fear of transgender status being revealed, and a lack of provider sensitivity and expertise. Because of high rates of poverty, transgender persons are disproportionately dependent on the Ryan White system of care to help support core medical services.

In 2011, the San Francisco HIV Health Services Planning Council commissioned a **needs assessment of transgender women living with HIV** in San Francisco, San Mateo, and Marin counties to guide the Planning Council in its decision-making process regarding Ryan White Part A prioritization and allocation. The needs assessment was conducted by the University of California San Francisco Center of Excellence on Transgender Health, and findings were presented to the Council on August 20, 2012. Key issues in transgender women's access to and utilization of HIV services in the EMA included: a) Low levels of provider knowledge and cultural competence regarding trans-specific issues and medical concerns; b) Transportation issues; c) A perception that fewer services are available specifically for **African American** transwomen; and d) Low levels of awareness regarding available payer source across all service categories. Among other findings, the assessment recommended offering expanded provider training on transgender issues; carving out trans-specific components of existing Part A services; and ensuring the visibility of transgender people in peer and professional support roles.

To expand its response to the needs of transgender women in EMA, the San Francisco Department of Health in August 2012 received a new Special Projects of National Significance grant to specifically develop models of targeted HIV prevention, care, and support for transgender women, with the majority of program services to be provided by transfemale staff. The annual **cost** of providing HIV-related services to transgender persons in the San Francisco EMA is estimated to be at least **$5,625,000** per year.[57]

Emerging Population # 3: Men of Color Who Have Sex with Men (MSM): MSM overall make up by far the most heavily HIV-impacted population in the San Francisco EMA, accounting for **85.8%** of all persons living with HIV and AIDS as of December 31, 2012, including MSM who inject drugs (n=**19,857**). At least **6,500** of these individuals - or approximately **one-third** of the HIV-infected MSM population of the EMA - are people of color, most of them **African Americans** and **Latinos**. However, in calendar year 2012 in the city of San Francisco, **more than half** of all persons who tested positive for HIV (**53.8%**) were persons

of color, an increase of **12.1%** from 2006 (**188** of **392** new HIV infections). Within Latino communities in San Francisco, MSM make up **87.3%** of all persons living with HIV/AIDS, including **75.7%** infected through MSM contact and **11.6%** infected through MSM contact and injection drug use. Among Asian and Pacific Islander groups, the percentage is even higher, with MSM accounting for **87.7%** of all persons living with HIV/AIDS, including **78.6%** MSM only cases and **9.2%** MSM/IDU cases. The percentage of MSM cases among African Americans in San Francisco is somewhat lower, largely due to the fact that a much higher proportion of African Americans living with HIV and AIDS are women.

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 within the SF EMA is estimated at **$73,448,100**.[58]

Emerging Population # 4: Homeless Individuals: Homelessness is an ongoing crisis for the San Francisco EMA, contributing to high rates of HIV infection, and creating an intensive need for integrated, tailored services which bring homeless individuals into care, stabilize their life circumstances, and retain them in treatment. At least **1,621** HIV-infected homeless individuals are estimated to be living with HIV or AIDS in the San Francisco EMA at some point each year (based on an overall 7% homelessness rate among PLWHA), and at least **42%** of them are estimated to be out of care. Because of their disconnection from health and social service systems, homeless individuals are the population **least likely** to obtain regular health or preventive care. **Clearly, the most pressing service need for HIV-infected homeless people is to obtain safe, stable housing that allows them to enter care and to remain adherent with HIV medication regimens.** However, the scarcity of housing resources in the EMA makes it difficult for HIV-infected homeless people to obtain housing quickly, and many homeless individuals are lost to care while waiting for housing slots to become available. All current housing waiting lists in San Francisco are closed and the average waiting time for those already on lists is **10 years.** Rates of mental illness and substance addiction are disproportionately high among the homeless, complicating both outreach and care provision, and necessitating integrated service programs such as the CoE initiative. In August 2012, the San Francisco Department of Health received a new Special Projects of National Significance grant to develop a collaborative model outreach, treatment, and retention program targeted to chronically homeless men and women with HIV in San Francisco. The annual **cost** of providing HIV-related services to homeless persons in the SF EMA is estimated at **$19,460,000**.[59]

Emerging Population # 5: African Americans: The growing crisis of HIV among African Americans in the San Francisco EMA is cause for significant concern. As of December 31, 2012, a total of at least **3,042** African Americans were estimated to be living with HIV/AIDS in the EMA, representing **13.1%** of the region's HIV-infected population, despite the fact that only **4.3%** of the EMA's population is African American. At the same time, fully **16.8%** of all those newly diagnosed with AIDS between January 1, 2010 and December 31, 2012 were African American – a percentage **28.2%** higher than their representation in the overall PLWHA population. Women account for **18.1%** of all African American PLWHA in the EMA, as

compared to **6.5%** for the EMA as a whole, while heterosexually transmitted cases account for **9.7%** of African American PLWHA as compared to **3.9%** for the entire EMA. At least **30%** 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) continuing high rates of stigma within African American communities related both to HIV and the behaviors that transmit it; b) higher prevailing rates of poverty and unemployment, leading to lower rates of private insurance and health care utilization; and c) high rates of injection drug use and homelessness, leading to difficulty in accessing or prioritizing care. Of the 183 African Americans surveyed for the EMA's 2008 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. To successfully reach more HIV-infected African Americans, the local care system has had to engage in a more aggressive and comprehensive approach by locating culturally appropriate services within historically black neighborhoods to inform African Americans of the importance of HIV testing and proactively engaging them in treatment**. The Black Center of Excellence at the University of California San Francisco, supported with Ryan White Part A funds, are making a significant contribution toward addressing this discrepancy.** In addition, in 2010, the San Francisco Planning Council completed an **African American Women's Needs Assessment** which significantly expanded our understanding of the needs and life circumstances of this population and aided in the prioritization and allocation of service funding. The annual **cost** of providing HIV-related services to African Americans within the SF EMA is estimated at **$38,322,000**.[60]

Emerging Population # 6: Latinos: In the San Francisco EMA, the Latino population makes up a growing percentage of the region's total HIV-infected population. While **18.0%** of all PLWHA in the EMA as of December 31, 2012 were Latino/a, **21.6%** of new AIDS cases diagnosed between January 1, 2010 and December 31, 2012 were among Latino/as. A total of **4.162** Latino/a PLWHA estimated to be living in the EMA as of the end of 2012. According to the most recent San Francisco HIV Epidemiology Report, Latinos represent **31%** of young adult AIDS cases age 20-24 in the city and an alarming **44%** of adolescent AIDS cases age 13-19 – a clear overrepresentation when compared to the **26%** 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 in the Latino population. 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 by culturally competent professionals who understand the health beliefs and practices of Latino communities. Fear of jeopardizing naturalization opportunities also leads to a reluctance to seek HIV testing or treatment. The **Mission Center of Excellence** operated by Mission Neighborhood Health Center and funded through MAI funding provides culturally competent, integrated, bilingual/bi-cultural HIV services to over **400** Mission neighborhood residents, with an emphasis on Spanish-speaking clients, in order to enhance their quality of life and promote individual and community empowerment. The annual **cost** of providing HIV-related services to Latino populations in the SF EMA is estimated at **$56,196,500**.[61]

1.E) 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 facing an economic crisis which threatens both the quality and availability of care for persons with HIV/AIDS in the region. This crisis stems from a convergence of factors creating an environment in which the system is 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 medical care and retain them on combination therapies. The factors underlying this threat fall into **three** broad categories: **1)** The growing population of persons living with HIV infection, including individuals with complex and multiple needs; **2)** Escalating co-morbidities which threaten to swamp the system and create overwhelming demands on care providers, including increasing number of persons with HIV age 50 and older; 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 issues - described briefly below - places a particular burden on the system of care, and presents challenges to a Planning Council struggling to maintain an adequate level of support for **all** impoverished persons with HIV. California's massive 2009 health and human service funding cuts – including reductions of **$59.1 million** in support for HIV/AIDS programs throughout the state – only complicate the ongoing challenge of delivered effective, life-prolonging care to a growing and increasingly impoverished population.

Growing Population of Persons with HIV including Individuals with Multiple Needs: It is important to remember that despite diminishing financial resources, there are today more persons living with HIV in the San Francisco EMA than at any point in the history of the epidemic - an increase of more than 50% over the last 12 years alone. **This crisis requires increased resources, not reduced ones.** The estimated **23,164** persons living with HIV and AIDS as of 12/31/12 represents **69.2%** of the total 33,469 AIDS cases **ever diagnosed** in the San Francisco EMA, and is **nearly 50% more** than the 22,384 people who had **ever died** from AIDS in the region through the end of 2012. Because of our unparalleled success in bringing large numbers of persons with HIV into care, supporting the cost of their medications and treatment, and providing help for them to remain stable and compliant, persons with HIV in the region are living much longer and more productive lives than would previously have been thought possible. At the same time, they are progressing to AIDS at a slower rate, despite the growing need and complexity of the HIV-infected population. **The reduction in the rate of new annual AIDS cases in the region is a sign of the success of the San Francisco system of care in preventing HIV-infected people from progressing to AIDS.**

But local HIV-infected populations are not only growing – they are becoming much more challenging to serve, presenting a greater range of pre-existing physical, psychosocial, and financial issues than at any point in the past. The characteristics of the local epidemic are staggering: **Two-thirds** of persons living with HIV and AIDS and **one hundred percent** of persons in the Ryan White system are living at or below 300% of federal poverty level;[62] **One in five** persons with HIV have no form of health insurance;[63] nearly **one in ten** persons newly diagnosed with AIDS in the EMA is homeless;[64] as many as **half** of MSM living with HIV in the EMA suffer from depression;[65] **thirty percent** of local PLWHA are active substance users;[66] **one in seven** persons with HIV in the EMA speaks a primary language other than English;[67] **as many as one-third** of gay-identified men in the San Francisco EMA may be HIV-infected;[68] and **thirty-five percent** or more of transgender persons are believed to be HIV-infected, including **over half** of all African American male-to-female transgender persons.[69]

Ironically, it is in part 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

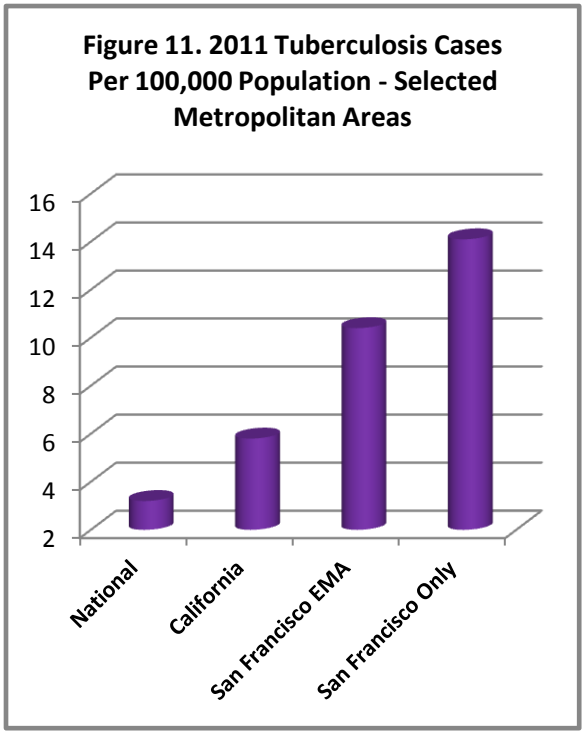
unprecedented pressures with which it is currently struggling. Success in increasing lifespan compels the system to provide supportive services, including financing medications for a growing population over an increased length of time. Additionally, more and more individuals move to the San Francisco EMA to access its high level of services, creating a growing burden on the system from outside the region without adding to the its reported HIV/AIDS caseload because these individuals were first diagnosed with HIV elsewhere. A recent review by the San Francisco Epidemiology Unit found that at least **1,221** PLWHA whose cases reside in other jurisdictions sought and received HIV care in the SF EMA from 2008 - 2010. At least another **1,000** additional out-of-region PLWHA received care but were not counted in the system because of missing HIV test documentation. All PLWHA participating in the 2008 San Francisco HIV Needs Assessment, for example, were asked where they had received their original HIV diagnosis and **nearly 40% reported that they had initially tested positive for HIV outside the San Francisco EMA**, and had moved to the region to receive care.[70]

Escalating Co-Morbidities: Section 1.B above describes several co-morbidities critical to the complexity of providing care in the San Francisco EMA. However, these are by no means the only key issues contributing to the growing complexity of the HIV epidemic in San Francisco. The problem of **substance use**, for example, plays a central role in the dynamics of the HIV epidemic, creating challenges for providers while presenting a critical barrier to care for HIV-infected consumers. The EMA is in the throes of a major substance abuse epidemic which is fueling the spread not only of HIV but of co-morbidities such as sexually transmitted infections, hepatitis C, mental illness, and homelessness - conditions that complicate the care system's ability to bring and retain PLWHA in care. According to the most recent report by the California Office of Statewide Health Planning and Development, an average of **8.5** hospitalizations per 10,000 occurred in San Francisco, well above the average statewide rate of **6.6** per 10,000.[71] At the same time, the rate for drug-induced deaths in San Francisco stood at **24.8** per 100,000, more than double the statewide rate of **10.8** per 100,000.[72] 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**.[73] In terms of HIV, the most alarming current threat involves the local epidemic of **methamphetamine** (**speed).** Health experts currently estimate that up to **40%** of gay men in San Francisco have tried methamphetamine,[74] and recreational crystal use has been linked to **30%** of San Francisco's new HIV infections in recent years.[75]

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 on Drug Abuse (NIDA), the total costs of drug abuse and addiction due to use of tobacco, alcohol, and illegal drugs are estimated at **$524 billion** a year and illicit drug use alone accounts for **$181 billion** in health care costs, lost productivity, crime, incarceration, and drug enforcement.**[76]** 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.[77]** 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 in San Francisco cost between **$2,068** and **4,458** for a single course of treatment.[78]

Injection drug use in the San Francisco EMA is closely related to the growing local epidemic of **hepatitis C**. Because it is a blood-borne infection, hepatitis C is closely tied to injection drug use, and is a frequent co-factor for persons living with HIV/AIDS, complicating care and often leading to severe long-term health consequences. **SF DPH 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 tolerate new treatments, and is the leading cause of death from chronic liver disease in America.[79] 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 and oral ribavarin costs more than **$20,000.**[80] 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.**[81] **The HIV care system is rapidly becoming the default medical provider for many persons with hepatitis C - a trend which, as persons with HCV age, will place enormous cost burdens on the 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 TB crisis is comparable to syphilis and gonorrhea, with a total of **185** new cases of TB diagnosed in the SF Metropolitan Area in 2012, representing an EMA-wide incidence of **10.4** cases per 100,000.[82] In San Francisco, the incidence is even higher, at **14.1** cases per 100,000. San Francisco County's 2012 TB rate ranked second in California out of 58 counties, while San Mateo ranked seventh and Marin County ranked 14th. **San Francisco's TB incidence rate is more than double than the statewide rate of 5.8 cases per 100,000 and nearly four times higher than the national rate of 3.2 cases per 100,000** (see Figure 11).[83] Treatment for **multidrug-resistant tuberculosis** is particularly expensive, with one study indicating that the cost averaged **$89,594** per person for those who survived, and as much as **$717,555** for patients who died.[84]

The high prevalence of **mental illness** and **mental health issues** in the San Francisco EMA further complicates the task of delivering effective services and retaining persons with HIV in care. The San Francisco Department of Public Health, Behavioral Health Section reported in its most recent report that **12,000** seriously emotionally disturbed children and youth and **32,000** seriously mentally ill adults live in San Francisco, and that up to **37%** of San Francisco's homeless population suffers from some form of mental illness.[85] In part because of the Golden Gate Bridge, San Francisco also has one of the nation's highest rates of both adult and teen suicide completion, and the rate of suicide per capita in San Francisco is **twice as high** as the city's homicide rate.[86] When coupled with the second highest incidence of homelessness in the US, these statistics reflect the high 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%.**[87] 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.[88]

Concentration of HIV/AIDS Cases: Imagine standing in a crowded bus or train during rush hour in a major U.S. city. On that train in San Francisco, the odds are extremely high that at least **two** people will have HIV. As noted above, **1 in every 40** 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 combinations of full-time and part-time staff, resulting in higher levels of employee turnover and attrition.

1.F) Impact of Decline in Ryan White Formula Funding

The San Francisco EMA has experienced two sudden and dramatic reductions in Ryan White Part A funding over the past two fiscal years. with support dropping from a total of $25,640,788 in FY 2011 to $17,925,024 in FY 2013, a loss of $7.72 million or nearly 30% in only two short years. Between FY 2012 and FY 2013 alone, Part A formula funding dropped from **$20,844,439** to **$17,925,024,** a total of nearly **$2.9 million.** These cuts are largely related to the hold harmless provision of the Ryan White HIV/AIDS Treatment Extension Act of 2009 which does **not** include a supplemental funding restoration to the San Francisco EMA for the period 2010 - 2014. While our region was fortunate to have much of these cuts restored for the current fiscal year out of San Francisco County General Funds, this support is not guaranteed in the future, and is susceptible to dramatic future reductions based on the continuing economic crisis in the State of California. The dramatic reductions in the present fiscal year are on top of a series of reductions in Part A formula and supplemental funds that have stripped nearly **50%** of the EMA's combined Ryan White funding over the past decade and a half. Continual reductions in formula and supplemental funding over the past half decade have, in the past led to the broadening of waiting lists at a number of key agencies and regional Centers of Excellence – including the Mission Center of Excellence - and to a lack of immediate access to care for newly infected individuals. In July 2008, a highly popular HIV dental clinic located at University of the Pacific in San Francisco was forced to discontinue clinics due to cuts in State Denti-Cal reimbursements, depriving hundreds of low-income HIV-infected men and women of quality dental care. And in early 2012, the city's HIV care system was dealt a significant blow by the closing of Tenderloin Health Services, an agency specializing in HIV care and support for the San Francisco's most highly marginalized populations. Prior Part A funding reductions also forced the agency Continuum to close its unique adult day care program located in the Tenderloin area of San Francisco and eliminated a medical van transportation service provided by Shanti which has since created significant barriers in accessing care. In Marin County, reductions forced the elimination of the region's Volunteer Services program which provided practical, emotional, and transportation support to clients, including programs for driving clients to medical appointments and training disabled persons with HIV to learn marketable computer skills. Marin County funding cuts also made it unfeasible to contract with the Marin Community Food Bank to provide home-delivered food to homebound clients. Instead, the County's food service now consists of food gift cards made available to only the most severe need clients who must now shop for and prepare their own meals. **To preserve a basic level of care for persons**

with HIV in the hard-hit Bay Area region, the SF EMA seeks a significant measure of Part A formula and supplemental funding restoration through the FY 2014 allocation process to avoid significant reductions in the quality and length of life of persons with HIV in the region.

1.G) UNMET NEED

1.G.1) Unmet Need Framework - See **Table** in **Attachment 6**

1.G.2) Process for Updating the Unmet Needs Estimate

This year's unmet need analysis included persons living with AIDS (PLWA) and persons living with HIV/non-AIDS (PLWH) in the San Francisco EMA during the 12-month period from **July 1, 2011 through June 30, 2012.** The analysis incorporated an estimate of overall unmet need as well as subpopulation analyses for both PLWA and PLWH. These estimates were produced by the SFDPH Applied Research, Community Health Epidemiology, and Surveillance Branch, and utilize the unmet need framework methodology developed by the University of California, San Francisco Institute of Health Policy Studies – the framework that is specifically recommended by HRSA. The timeframe chosen for the unmet need analysis was based on the most recent 12-month interval for which care data were complete from all available data sources.

Data Sources: The **Enhanced HIV/AIDS Reporting Systems (eHARS)** maintained by each of the three counties in the San Francisco EMA (in collaboration with the State of California Part B program) were the main data sources for PLWA and PLWH population estimates. Care information was obtained from data sources such as provider chart reviews in all counties and reporting of viral load and CD4 results from public and private laboratories, including the laboratory at the SF VA Medical Center. Through collaboration with the California Part B program, SFDPH also obtained a file containing patient-level care information for the EMA from the California State eHARS system, AIDS Drug Assistance Program (ADAP), AIDS Regional Information and Evaluation System (ARIES), and Kaiser Permanente Northern California (the largest private health care provider in the state). Records from the various data sources were merged into a single dataset by soundex, date of birth, and gender, and then unduplicated.

Population Estimation Methods: Reporting of AIDS cases in the SF EMA is **close to complete**. For all counties in the SF EMA, numbers of PLWA and PLWH were derived directly from cases reported in the linked eHARS databases and supplemented by additional unduplicated patients from the California patient care file (described above in Data Sources). This represents a simplified methodology compared to that used in previous years, when less complete eHARS data required us to estimate the number of PLWH aware of their infection for one or more counties. HIV/AIDS populations at San Quentin State Prison in Marin County were excluded from estimates because HIV-infected prisoners at this facility are often transferred out of the county after receiving an HIV diagnosis and do not access the County's private or public health care system while incarcerated. However, their numbers are included in our overall epidemiological table (see **Attachment 3**) because they receive a diagnosis of HIV within our EMA.[89]

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 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, 2011 through June 30, 2012**. Separate unmet need estimates for PLWA and PLWH could be generated as all population and care data sources contained information on AIDS/HIV status. The number of PLWA in care for Marin County and San Mateo 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, the proportion of PLWA in care was calculated using a representative subset of PLWA living in San Francisco County (n=8,470). The proportion of PLWA receiving care as determined in the sample was then applied to the total number of PLWA to derive the number of PLWA who received care in San Francisco. 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 the unmet need table in **Attachment 6**.

Findings: Estimates of Populations, Persons in Care and Unmet Need from July 1, 2011 through June 30, 2012: An estimated **12,541** PLWA and **8,250** PLWH who were aware of their HIV status resided in the San Francisco EMA from July 1, 2011 through June 30, 2012 (see Table in **Attachment 6**). A total of **1,041** PLWA and **1,461** PLWH did not receive primary medical care during that time period. Unmet need was thus **12%** overall, and - as would be expected - was higher among PLWH (**18%**) than among PLWA (**8%**). The 12% overall unmet need estimate is very close to last year's estimate of 11%.

1.G.3) Unmet Need Trends

The table below shows the percentage of unmet need in San Francisco for fiscal years 2010–2012, based on calculations made for a July 1 – June 30th cycle for each year and reported in each year's Ryan White Part A application. **The table shows a leveling off in the percentage of persons with unmet need in the EMA between FY 2011 and FY 2012, following a decrease between FY 2010 and FY 2011.** This change may be due to more complete HIV surveillance reporting, which would capture more PLWH not regularly receiving care.

Reported Percentages of Unmet Need in San Francisco EMA – FY 2010 - FY 2012		
FY 2009-2010	**FY 2010-2011**	**FY 2011-2012**
14%	**11%**	**12%**

1.G.4) Incorporating Unmet Need Data in Planning & Decision-Making

Demographics and Location of People Who Know Their HIV Status but are Not in Care: Continually enhanced data collection and reporting systems in the San Francisco EMA have given our region ability to compare specific unmet need among PLWHA. For the period July 1, 2011 through June 30, 2012 we estimated these populations across **four** critical categories: HIV/AIDS status, gender, race/ethnicity, and age group – results that are reported in Figure 12 on the following page. While San Francisco has pioneered several new approaches to mapping HIV-infected PLWHA in the city using zip codes and census tracts as a way to help target HIV testing outreach and prevention efforts. However, these methods are unreliable in terms of predicting place of residence for persons who are either out of care or unaware of their HIV status, in part because of the transience of persons with HIV in San Francisco and in part because of the extensive in-migration of persons with HIV who travel to the EMA seeking care.

Trends Associated with the Past Three Years Regarding Unmet Need: The table in Section 1.G.3 above lists percentage of unmet need in San Francisco for the years 2009–2011, and demonstrates a continued reduction in the percentage of persons with an unmet need for HIV primary medical care in the San Francisco EMA, from **14%** in FY 2010 to **11%** in FY 2011 to **12 %** in FY 2012. As noted above, the decrease in unmet need is believed to be based on the EMA's continuing success in aggressively identifying and linking to care persons who had either dropped out of care or who had previously been unaware of their HIV status. It can also be

Figure 12.
San Francisco EMA Demographic Analysis of People in and Out of Care
July 1, 2011 through June 30, 2012: ALL Persons Living with HIV or AIDS (PLWHA)*

Characteristic	#1: PLWHA Population	#2: Number with Met Need	#3: Number with Unmet Need	#4: % of Unmet Need Population**	#5: % of Category with Unmet Need**	#6: % of Total PLWHA Population**
All PLWHA	20,791	18,289	2,502	100%	12%	100%
HIV/AIDS Status						
PLWA	12,541	11,500	1,041	42%	8%	60%
PLWH / no AIDS	8,250	6,789	1,461	58%	18%	40%
Gender at Birth						
Male	19,241	16,912	2,329	93%	12%	93%
Female	1,550	1,377	173	7%	11%	7%
Race/Ethnicity:						
White	12,391	10,938	1,453	58%	12%	60%
African American	2,848	2,482	366	15%	13%	14%
Latino	3,853	3,409	444	18%	12%	19%
Asian/PI	1,159	1,007	152	6%	13%	6%
Other	540	453	87	3%	16%	1%
Age in Years*:						
0-19	54	42	12	<1%	22%	<1%
20-29	1,045	851	194	8%	19%	5%
30-39	3,028	2,495	533	21%	18%	15%
40-49	7,433	6,510	923	37%	12%	36%
50-59	6,416	5,817	599	24%	9%	31%
60 or older	2,815	2,574	241	10%	9%	13%

* Age at the beginning of the time period.
** Column calculations: Column #4 = Column #3 / total with unmet need (n=2,502); Column #5 = Column #3 / Column #1; Column #6 = Column #1 / total number PLWHA (n=20,791)

attributed in part to an ongoing decrease in the number of new persons becoming infected with HIV in the EMA each year, which helps explain why fewer individuals who are living with non-AIDS HIV are unaware of their HIV status. A comparison of this year's data with the unmet need demographics data produced three years ago, for the period July 1, 2008 through June 30, 2009, reveals, for example, that while persons with non-AIDS HIV made up **70%** of the total unmet need population two years ago (n=**2,567**) they make up only **58%** of the unmet need population this year (n=**1,461**). At the same time, while the percentage of out-of-care PLWA has increased from **30%** to **42%,** the actual number of out-of-care PLWA has actually **decreased** over the same two-year period, from **1,115** to **1,041**. Few other significant demographic changes in the out-of-care population have occurred over the past two years, with the exception of a minor increase in the percentage of out-of-care Latinos from **16%** to **18%**. As expected, the percentage of persons with HIV age 50 and older has continued to increase, rising from **41%** for the period 2008-2009 to **44%** in 2011-2012.

Methods Used to Assess Service Needs, Gaps, and Barriers to Care for People Not in Care: Assessment of service gaps and barriers to care for out-of-care populations remains a critical component of the EMA's comprehensive needs assessment process. The last full-scale needs assessment, conducted in 2008, included a significant focus on persons not in care. 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. At the time of the assessment, these and other findings led to strengthened funding request for Centers of Excellence programs specifically directed toward **African Americans** and **women**, while work in collaboration with local CoEs was strengthened to extend outreach efforts to out-of-care populations while continuing to support Treatment Adherence to help complex populations remain in care.

How Results of the Unmet Need Framework are Reflected in Planning and Decision Making in the SF EMA: Results of the Unmet Needs Framework analysis are presented to the San Francisco HIV Health Services Planning Council during the prioritization and allocation process and play a critical role in helping influence and shape both service category and funding decisions. Findings related to unmet need among ethnic minority populations, for example, have 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. Findings related to unmet need among young people have influenced decisions to continue prioritizing substance abuse services to address chemical addiction barriers that can limit young people's ability to access HIV testing and care. The Unmet Needs Framework is an important 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.

METHODOLOGY

1) Planning and Resource Allocation

1.A) Letter of Assurance from Planning Council Chairs - See **Attachment 7**

1.B) Description of Priority Setting and Resource Allocation Process

1) Consideration of Needs of Persons Not in Care: The San Francisco HIV Health Services Planning Council utilized a range of approaches to understand and incorporate the needs of out of care PLWHA throughout FY 2014 its prioritization and allocation process. The

Council utilized the **Unmet Needs Framework** as a tool to quantify the number of individuals living in the EMA who are aware of their HIV status but are not currently in care. The Council also utilized a **demographic chart** of unmet needs populations developed the San Francisco HIV Epidemiology Unit which broke down the out of care population by projected demographic categories such as ethnicity, age, gender, and HIV transmission, and helped the Council project some of the potential needs of out of care individuals who may be brought back to the system in the coming months and years. The Council continued to be informed by the findings of its previous Comprehensive Needs Assessment which included significant qualitative input from out of care populations and has influenced decisions on how best to tailor services to overcome barriers to care for PLWH. The Council also received briefings on San Francisco neighborhood-based community viral load, providing information on intermittent care seekers.

2) Consideration of Needs of Persons Unaware of their HIV Status: The Planning Council relied on a combination of quantitative and qualitative data to assess the needs of unaware populations into its current prioritization and allocation cycle. From a quantitative standpoint, the most important document the Council considers is the **EMA-Wide Epidemiological Chart** developed each year for the Ryan White Part A application which utilizes epidemiological consensus to provide a reliable estimate of the size and scope of the population of persons living with HIV in the region, including persons with HIV who are unaware of their status. The EMA has developed this chart each year for nearly a decade, and it is used by the Planning Council both to anticipate new populations who may enter the system in the future and to flag potential emerging challenges in the epidemic related to emerging epidemiological trends. From a qualitative standpoint, the Council works in close partnership with the San Francisco HIV Prevention Section to plan collaborative approaches to HIV outreach, testing, and care linkage and to develop points of integration between prevention and care wherever possible. A large share of these activities have been taken up through the local ECHPP process, which incorporates strong participation by members of both Councils and continually reports back to the Councils on new initiatives related to HIV-unaware groups.

3) Consideration of the Needs of Historically Underserved Populations: The San Francisco Planning Council has placed a historical emphasis on meeting the needs of underserved populations, and on developing care systems which facilitate entry and retention in care for these groups. This approach is consistent with the overall purpose of Ryan White funding, which is in part to develop systems that allow highly underserved individuals to access high-quality HIV care, treatment, and support services regardless of income status. The San Francisco EMA's entire model of care is in fact structured around the need to ensure access to care for underserved populations, including its Centers of Excellence program, which is specifically designed to address retention and care access barriers for underserved populations with special needs such as women, African Americans, Native Americans, and recently incarcerated individuals. Centers of Excellence service utilization data consistently attests to the success of this approach in achieving high care representation among those groups who most commonly face barriers to health care access in America, including low-income individuals and families, persons of color, women, gay and bisexual men, transgender persons, active substance users, homeless individuals, and persons with mental illness. The Council continues to use its success in meeting the needs of these populations as a benchmark for tracking its own effectiveness in addressing the goals of the Ryan White program.

4) Involvement of Persons Living with HIV/AIDS: As in previous years, persons living with HIV and AIDS (PLWHAs) were integrally involved in all phases of the FY 2014 priority-setting and allocation process. Self-identified persons living with HIV currently make up **55%** of the membership of the San Francisco HIV Health Services Planning Council, including **16** non-

aligned consumers comprising **43%** of Council membership. Council bylaws require that at least one Council Co-Chair be a person with HIV and a consumer of Ryan White services, and the Council strives to ensure that at least one co-chair for each committee is a person with HIV.

The Council also relied heavily on its **2008 San Francisco EMA Health Services Needs Assessment**, which included in-depth client surveys completed by 248 persons living with HIV and/or AIDS in all three counties; a series of 3 population-specific focus groups attended by a total of 26 individuals; and on-on-one interviews with a total of 11 recently incarcerated individuals.[90] The assessment over-sampled members of the **African American** community to better identify needs among members of this hard-hit and historically underserved population, with **38.9%** of the total study sample consisting of African Americans living with HIV/AIDS. To expand our understanding of **homeless populations**, fully **21%** of all those participating in the needs assessment were also persons considered to be homeless.

The Council also utilized a **Follow-Up Qualitative Study to the Needs Assessment** published in June 2010 which provided an in-depth exploration of the needs of **three** key emerging subpopulations in the San Francisco EMA: African American women, older adults, and hepatitis C co-infected individuals.[91] The study also included a focus group made of HIV service providers. Among the most significant findings of the study was the fact that while persons 50 and older with HIV are generally satisfied with the quality of medical care they are receiving, they are concerned that medical providers are not prepared to deal with the health needs of the burgeoning HIV-positive geriatric population. Participants are also concerned that doctors may not be able to differentiate which symptoms are specific to aging versus HIV, and there was general concern regarding the lack of research on the implications of taking HIV medications over long periods of time. The Needs Assessment was instrumental in guiding FY 2014 prioritization and allocation, and ensured that the needs and perspectives of persons living with HIV/AIDS – including those not in care – were continually incorporated into the process.

5) <u>Consideration of Current Data Sources:</u> As in past years, the Planning Council received a range of high-quality data - including unmet needs data - to assist in prioritizing FY 2014 services and allocating resources, with an emphasis on HRSA-identified core medical services. Among the data presented, reviewed, discussed, and incorporated by the Council in its decision-making this year were the following:

- Background information on requirements and parameters of the Ryan White HIV/AIDS Treatment Extension Act of 2009, including definitions of core service categories;
- A detailed analysis of each priority service category funded and not funded by the Council in FY 2013 by county, including service definitions; budgeted and actually funded service category amounts; populations served; key points of entry; utilization reviews; other funding sources available in each category; and possible impacts of cuts in each service category;
- A comprehensive, updated HIV/AIDS Epidemiology Report by the SF AIDS Office detailing current PLWHA populations and discussing current trends in the epidemic;
- A detailed analysis of client-level data reported through the ARIES data system for the period March 1, 2012 through February 28, 2013, including information on the demographic characteristics and changing health status of Ryan White-supported clients and service utilization data related to all Part A services;
- A summary of findings from needs assessments commissioned by the Planning Council, including the Comprehensive Assessment and Follow-Up Qualitative Study;
- A summary estimate of unmet need among PLWHA in the San Francisco EMA utilizing HRSA's unmet needs framework;
- A detailed presentation on other funding streams in the EMA, with a special focus on federally funded programs and on programs funded through MAI support, as well as Part B,

Part C, Part D, and Part F funding through the San Francisco Department of Health, and other sources;

- A review of goals and objectives from the 2012-2014 Comprehensive HIV Health Services Plan, along with updated progress reports for each goal, objective, and action step; and
- Consensus input to the Planning Council from the San Francisco HIV/AIDS Provider Network, a group of 43 community-based, non-profit HIV service agencies in the San Francisco EMA meeting the needs of persons living with HIV and AIDS.

These and other data were utilized by the Council in part to ensure that proposed FY 2014 allocations increased access to HRSA-identified **core services**. The final FY 2014 Implementation Plan resulted in a combined allocation for HRSA core medical services that represents **76.53%** of the EMA's total direct service funding request (see table in **Attachment 8**), exceeding the required 75% core services requirement.

6) 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. The Council reviewed a comprehensive, updated HIV/AIDS Epidemiology Report prepared by the San Francisco AIDS Office detailing current PLWA / PLWHA populations and discussing current trends in the epidemic which directly influenced key prioritization and allocation decisions by the Council. For example, the Council affirmed its commitment to the Centers of Excellence program as a strategy for helping address growing HIV infection rates among young women of color and MSM of color. The Council also discussed the growing proportion of PLWHA 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. This included receiving an update on a recently funded grant to HIV Health Services through the California HIV/AIDS Research Program that will support the development and evaluation of innovative new models of care for persons with HIV 50 and older at two of the largest HIV clinics in San Francisco: Ward 86 at San Francisco General Hospital and the 360 Program at the University of California San Francisco Medical Center.

7) Applying Cost Needs Data to Part A 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 Part A service category. This included a full utilization review for each Part A service category listing total dollar amounts, unduplicated clients and cost per unit of service; a listing of all non-Part A 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. The Council also received a detailed presentation on other funding streams in the EMA, including a summary of Part A, MAI, Part B, Part C, Part D, SF DPH, HOPWA, and other funding sources such as Medicare, private insurance funding, and funds provided through the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). The funding streams presentation also included information on the history, current funding and programmatic levels, 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 care.

8) Applying Unmet Needs Data to Part A Service Allocation: As noted above, the Planning Council reviewed a summary estimate of unmet need among PLWA and PLWHA 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 Comprehensive Needs Assessment, Qualitative Update, and most recent Comprehensive Plan also included a heavy emphasis on assessing unmet HIV service needs specifically, yielding critical information that was used by the Council in its prioritization and allocation process. This included information ranking Part A service categories in terms of those most utilized and most needed by PLWHA, along with recommendations for addressing gaps in service delivery to ensure a more comprehensive system of care. Key unmet needs findings contained in the 2008 assessment, for example, included recommendations to: a) increase the availability of substance use services for PLWHA; b) enhance transportation services for severe need clients; c) explore potentially effective pharmaceuticals that are not currently included in the California ADAP formulary; and d) address housing disparities in regard to ethnicity.

9) Planning for Potential Fluctuations in the Part A Award: As in previous years, the Planning Council developed a **contingency plan** offering a blueprint for how the Council would respond to potential increases or decreases in FY 2014 Part A funding: 1) If allocation levels **remain the same**, allocations for all service categories will remain at flat funding; 2) If allocation levels are **decreased**, the first **5%** of cuts will be made to service categories that are covered under California's ACA Essential benefits package; and 3) If allocation levels are **increased**, allocations for **Benefits Counseling, Dental Services,** and **Legal Services** will be increased up to **125%** of the current funding levels, largely to provide support to the EMA's growing number of older HIV-infected individuals. If resources become available beyond that allocation, allocations will be shared proportionately across all service categories.

10) Consideration of MAI Funding: The Planning Council received a comprehensive summary of the specific services currently funded through Minority AIDS Initiative funding, and incorporated MAI allocations decisions into its overall FY 2021 allocations process. The summary detailed specific goals of the local MAI process; historical funding levels received in the region; previous and current expenditures with that funding; specific outcomes achieved in regard to minority health, health access, and service utilization; and a quantified report on the demographics of populations served through MAI funding. This report validated the success of the EMA's approach to MAI allocations, and affirmed the key role that MAI funding plays in helping reduce HIV disparities while meeting the needs of historically underserved populations.

11) Incorporation of EIIHA Data: EIIHA information presented in the FY 2013 Part A application was directly incorporated into consideration of FY 2014 Part A priorities and allocations. As noted above, San Francisco HIV Health Services also works with epidemiologists in each of the EMA's three counties to develop an annual estimate of the total number of persons living with HIV in the region, **including** persons who are unaware of their HIV status. This estimate is provided in the annual Epidemiological Table contained in the Ryan White application and is utilized to detail the characteristics of the local HIV-infected population in the application's epidemiological profile. The estimate is based in part on an **annual consensus process** in San Francisco in which epidemiologists meet to develop an estimate of the total number of persons living with HIV – including people who do not yet know their HIV status – in proportion to persons living with AIDS. The estimates produced through this process are used to inform Planning Council decision-making and to anticipate client needs on an ongoing basis.

12) Incorporation of Data on Other Federally Funded HIV/AIDS Programs: As noted above, the FY 2014 prioritization and allocation process incorporated ongoing consideration of both financial and programmatic data related to all federal sources of HIV/AIDS funding in the San Francisco EMA. In addition to Ryan White funding, this includes funding sources such as

Medicaid and Medicare, the Centers for Disease Control and Prevention (CDC), and funds provided through the Substance Abuse and Mental Health Services Administration (SAMHSA).

13) Potential Changes through the Affordable Care Act (ACA): The Planning Council is strongly aware of potential impending changes through the Affordable Care Act (ACA) and took these potential changes into account while prioritizing and allocating FY 2014 resources. While the precise scope of changes to be realized through the ACA are not yet known, California and the San Francisco EMA have already begun to feel the impact of shifting resources through implementation of ACA-eligible low-income persons in the California Low Income Health Program (LIHP), California's bridge to ACA care. Perhaps the most immediate impact in regard to FY 2014 Part A funding was a Planning Council vote to reduce funding this year for direct outpatient ambulatory health services and to increase funding for medical case management services to better support linkage to and retention in care for the region's hardest hit groups.

1.D) Funding for Core Medical Services -

See Table listing planned Part A services for FY 2013 verifying that requested support exceeds the 75% core medical services allocation requirement in **Attachment 8**.

1. E) Early Identification of Individuals with HIV/AIDS (EIIHA)

1.E.1) EIIHA Plan Background Summary

Summary of Previous EIIHA Plan Development and Implementation:

Information to Inform the Plan: Development of the FY 2012 and 2013 San Francisco EMA EIIHA Plans involved a multi-phased planning effort incorporating a wide range of data, informational materials, consumer input, and expert feedback. Utilization of **up-to-date epidemiological information and unmet needs** data led to the development of prioritized populations which contain the greatest percentage of persons living with HIV/AIDS in the EMA. The Planning Council's most recent **client needs assessment surveys** provided input into unmet and under-addressed issues in regard to HIV testing, outreach, linkage, and retention, particularly in terms of HIV-positive out of care populations. The **2012-2016 Jurisdictional HIV Prevention Plans for the San Francisco Eligible Metropolitan Area (EMA)** - encompassing Marin, San Francisco, and San Mateo Counties and published in February 2013 - also provided critical guideposts for prioritizing EIIHA activities and objectives in relation to local target populations. The EIIHA strategy as a whole was developed and reviewed in close collaboration with staff of the **San Francisco Community Health Equity and Promotion Branch** (which includes staff of the former San Francisco HIV Prevention Section) and in conjunction with the **San Francisco HIV Prevention Planning Council** and the HIV prevention units of Marin and San Mateo counties.

Principal EIIHA Objectives: The San Francisco EMA oversees a well-developed system of HIV prevention and early intervention services that incorporates extensive public / private partnerships and employs innovative, cutting-edge approaches to reach, identify, and link persons with HIV who are unaware of their status to care. These systems are in part the result of the direct HIV prevention funding San Francisco receives from the US Centers for Disease Control and Prevention (CDC). As one of several jurisdictions nationwide to receive direct CDC funding, San Francisco has developed a complex local response to HIV prevention that incorporates HIV testing activities ranging from education and outreach to pre and post-test counseling in public and private settings to service referral and linkage to care. Under the leadership of the San Francisco Community Health Equity and Promotion Branch (CHE&P) and the San Francisco HIV Prevention Planning Council, our region has also developed comprehensive data reporting and tracking systems to measure the qualitative impact of its programs on specific populations which are cross referenced by neighborhood. San Francisco has been a leader in pioneering the use of **community viral load** to track the epidemic and

reduce HIV incidence by targeting high-risk neighborhoods and areas for enhanced HIV testing and linkage to care.[92] These approaches extend to the adjoining counties of the San Francisco EMA, and embody a regional prevention approach that involves all relevant providers in an effort to ensure that every door is the right door to HIV counseling, testing, and treatment, and that HIV testing consistently results in linkages to primary care and other direct services and support.

In order to address unmet testing and care linkage needs and reduce new HIV infections, particularly in light of current reductions in HIV-related resources, San Francisco is currently implementing a more upstream, structural approach to HIV prevention, including expanding testing and treatment access. This strategy includes a combination of interventions that reduce community-level risk for HIV. The **overarching goal** of the strategy - as expressed in the recently released 2012-2016 Jurisdictional HIV Prevention Plans for the San Francisco EMA - is to suppress individual and community viral load, thereby improving individual health and reducing HIV transmission risk at the community level, with the specific goal of **reducing new HIV infections in the San Francisco EMA by 50% by 2017**. Specific **objectives** enumerated in the Jurisdictional Plans are to:

- **Reduce new HIV infections among MSM by 50%;**
- **Reduce new HIV infections among TFSM by 50%;**
- **Eliminate new infections among IDUs;**
- **Eliminate perinatal infections; and**
- **Reduce disparities in new HIV infections.**

Collaborative Implementation Efforts: San Francisco's EMA-wide EIIHA approach incorporates close working partnerships with virtually all public and private providers of HIV outreach, testing, care, treatment, and linkage in the region. The long duration of the local HIV epidemic has necessitated that service system organizations be familiar with one another and develop collaborative relationships to facilitate mutual planning and data sharing. The relatively small size of the City and County of San Francisco also makes it easier to maintain a comprehensive knowledge of the area's social and health services, and facilitates promulgation of policies and approaches that better integrate prevention and care. The San Francisco Jail system, for example, is one of only four jail systems in the United States that includes a condom distribution program as well as recently added condom vending machines in each of the Central Jail's inmate units. Pre-release programs providing transitional plans for HIV-positive inmates are offered in both the county jails and at the San Quentin State Prison in Marin County as well as throughout the State. As in most regions, significant gaps continue to exist in the ability to track the number and outcome of HIV tests conducted in private hospitals, HMOs, and physician's offices.

The local process for developing a plan to respond to the **Enhanced Comprehensive HIV Prevention Planning and Implementation** for EMAs Most Affected by HIV/AIDS **(ECHPP)** initiative has further enhanced coordination and integration of local HIV prevention and care linkage services. The County Health Department now employs **three** new dedicated staff positions whose specific role is to coordinate, align, and maximize the effectiveness of the local continuum of HIV prevention, care, and treatment. One of these positions – **the Director of Strategic Integration** – is employed through CHE&P Branch and works throughout the Health Department and the local community to ensure that HIV outreach, testing, referral, and linkage is seamless and fully coordinated. Meanwhile, the **ECHPP Liaison** within HIV Health Services, funded through ECHPP, works to ensure alignment among CHE&P, HIV Health Services, the HIV Prevention Planning Council, and the HIV Health Services Planning Council efforts. Finally, the MAI Targeted Capacity Expansion (TCE) Manager, funded under the MAI-TCE

grant from SAMHSA, works to ensure the seamless integration of services for people living with and at risk for HIV who have co-occurring mental health and/or substance use issues that are impacting their health outcomes.

Also through the MAI TCE grant, two Behavioral Health Specialists provide services to Centers of Excellence clients (CCHAMP, Women's CoE, and Black Health CoE) who have mental health or substance use issues that are interfering with their ability to remain in care, adhere to treatment, and experience general well-being.

At the community planning level, the San Francisco HIV Health Services Planning Council and the HIV Prevention Planning Council (HPPC) are exploring ways to more closely integrate prevention and care planning efforts. Both Councils now include San Mateo and Marin representation, now that the prevention and care funding jurisdictions are composed of the same three-county area. The ECHPP Liaison has researched various integrated planning models and convened appropriate stakeholders (such as the Council Co-chairs and a combined Health Services Planning Council and HPPC work group) for discussion. The two Councils are prepared to vote in October 2013 on a model for integration, which will be implemented in 2014.

Target Groups in Current EIIHA Plan: The FY 2013 San Francisco EMA EIIHA Plan prioritized a total of **four** high-risk populations as the specific focus of Plan activities, consisting of the following:

1. **Males Who Have Sex with Males (MSM)**
2. **Injection Drug Users (IDU)**
3. **Transgender Females Who Have Sex with Males (TGF/M)**
4. **High-Risk Non-IDU Heterosexual Males and Females**

These high-risk populations were identified through close examination of up epidemiological data, qualitative client data, and emerging trends in the epidemic, and were determined through a group consensus process. The four populations included in the list account for more than **95%** of all persons living with HIV and AIDS in the San Francisco EMA, including the fastest-growing populations of persons newly infected with HIV. The FY 2013 Plan included analysis of specific barriers and challenges related to each of these populations, as well as prioritized activities to enhance the rate and impact of HIV outreach, testing, referral, and care linkage among these populations.

Collection, Analysis, and Utilization of EIIHA Data: Because EIIHA Plan activities are closely coordinated with ongoing HIV prevention, outreach, and care linkage activities conducted by public and private agencies throughout the EMA, the Part A grantee relies on a wide range of data sources and reports to track progress toward proposed EIIHA activities and objectives. These include:

- Utilization of prevention planning documents, guidelines, and strategies developed by the San Francisco Community Health Equity and Promotion Branch in collaboration with prevention and epidemiology staff in Marin and San Mateo counties;
- Participation in ECHPP planning activities whose partial goal is to better integrate HIV prevention and care services in the region;
- Ongoing review of local HIV public testing data in the San Francisco EMA, including demographic information on the total number of persons tested for HIV, the total number of new positives, and the percentage of new positives linked to medical care;
- Ongoing review of outreach, linkage, and retention support activities conducted by Part A-funded providers in regard to clients who have been lost to care or who are unstably engaged in care;
- Review of HIV outreach, testing, linkage, and retention activities conducted by agencies within the local Ryan White Part C and Part D care networks;

- Collaborative HIV testing and linkage planning through a collaboration between the San Francisco HIV Health Services Planning Council and the San Francisco HIV Prevention Planning Council;
- Review of client satisfaction and needs assessment data in relation to EIIHA activities collected by both the local Planning Council and by local public and private HIV service organizations; and
- Ongoing collaborative planning meetings to review progress toward enhancing the local HIV testing and linkage system and to develop new approaches to expand the effectiveness of local EIIHA activities.

Successful Outcomes of EIIHA Plan: The San Francisco EMA has been extremely successful in continuing to expand the scope and range of its efforts to identify and link to care more persons with HIV who are unaware of their status and more persons with HIV infection who are not currently engaged in care. San Francisco brought about a major enhancement of its HIV testing services matrix beginning in 2011 by implementing the new **Linkage Integration Navigation Comprehensive Services (LINCS) program,** modeled on the San Francisco General Hospital **Positive Health Access to Services and Treatment (PHAST) team**, a highly effective linkage/retention program still in operation. PHAST focuses on linkage and retention within the hospital while LINCS focuses on linkage and retention outside of the hospital, and also incorporates partner services. The LINCS Team provides a comprehensive range of services based on individual client needs and circumstances, incorporating linkage to HIV medical care, social services, partner services, and re-engagement services under a single umbrella.

LINCS employs an integrated team of **five full-time staff.** Three staff members provide individualized, tailored care linkage and re-engagement services and centralized access to services for the majority of persons testing newly positive in San Francisco. Two of these three LINCS Team members are based at high-volume citywide testing sites - one at San Francisco's nationally recognized Magnet Clinic and another at UCSF Alliance Health Project - while one "rover" serves lower-volume community-based testing and medical sites. These LINCS Team members also remain paired with newly identified individuals in a supportive relationship for **up to three months** following initial HIV diagnosis. The program strives to achieve the following **two** principal goals: **1)** to ensure that linkage to care is made **within 30 days** for **everyone** testing positive in San Francisco; and **2)** to ensure that **all** newly-diagnosed individuals are offered comprehensive and immediate linkage and partner services. **In 2012, 78% of all new diagnoses (n=200) were verified as having been successfully linked to care.** An additional **two** staff focus on providing navigation services to long-term HIV-positive clients who are at risk for falling out of care or are out of care, with a goal of ensuring that **no one** falls out of care, and if they do, that they are re-engaged with care as quickly as possible.

The LINCS Team also plays a critical role in facilitating identification of new persons with HIV by taking a leading role in **partner services (PS)** in the region. Formerly, when individuals in the EMA tested positive, they were given the option of speaking to a Health Department staff person regarding the PS program, an option that was often not chosen. Under the new system, however, each LINCS team member directly offers partner services to a newly identified person with HIV during the **initial** client encounter, with clients **strongly encouraged** to participate in the program. Additionally, because each LINCS Team member serves as both DPH linkage specialist and partner services representative, the PS message can be reinforced over time through contact with an individual the clients comes to know and trust. In order to expand the broadened partner services program to private care providers, the SF Department of Public Health maintains memoranda of understanding (MOUs) with at least **10** private physicians in the City who serve a high proportion of HIV patients to refer clients for partner services. The

incorporation of partner services into the LINCS Team model is expected to significantly increase the number of new HIV positive individuals identified in the San Francisco region. **In 2012, 350 newly diagnosed individuals received partner services, ultimately yielding 11 additional new diagnoses through identification of exposed partners.**

In 2011, San Francisco HIV Health Services also published a first-of-its-kind Best Practices Guide to Linkages from HIV Testing to Care (available at sfhivcare.com). The guide provides practical information on how best to facilitate care linkage for persons newly diagnosed with HIV, and advocates for a **client-centered approach** to linkage that takes into account the individual background, needs, and circumstances of client populations in supporting an effective transition to care. The guide also lays out guidelines for assessing the success of linkage efforts, and defines specific responsibilities for agency staff in the process of making referrals, supporting linkage, and ascertaining that effective linkages have taken place. The guide is available both at the HIV Health Services website and through a structured CD that has been distributed to all relevant testing and care agencies in the San Francisco EMA.

Major Challenges Encountered: A wide range of issues and challenges complicate the task of making individuals aware of their HIV status on a widespread basis. Many of these are the same challenges that have faced HIV prevention providers since the earliest years of the epidemic, including challenges such as the following:

- Challenges in making individuals aware of their personal HIV risk, the risks related to HIV infection, and the importance of early intervention in HIV treatment, including the need for education that is cultural, age, gender, sexuality, and language specific;
- Difficulties in bringing persons who do not normally access health services into HIV testing;
- The problem of overcoming HIV-related stigma, including the stigmas associated with HIV transmission behaviors;
- The need to overcome fears and misinformation regarding HIV treatment toxicity, including a historical mistrust of the medical profession; and
- The need to overcome fears of a loss of confidentiality or protection from status disclosure.

Contribution to Goals of the National HIV/AIDS Strategy: The goals and objectives of the EMA's EIIHA plan are fully consistent with the goals of the White House Office of National AIDS Policy's National HIV/AIDS Strategy, including the Strategy's three primary goals of: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.[93] Because it is **specifically focused** on the outcome of increasing the number of HIV-unaware individuals who are aware of their HIV serostatus, the local EIIHA strategy is also fully consistent with HRSA's goal of making unaware individuals aware of their HIV status, particularly in terms of reaching and testing highly impacted HIV populations in the San Francisco EMA.

Testing Data for Three Key Populations: To assess the scale and impact of HIV testing efforts on highly impacted local risk groups, the San Francisco EMA complied HIV testing data for the period **January 1- June 30, 2013** for the three most highly impacted target populations contained in the FY 2013 EIIHA Plan: **a) Males Who Have Sex with Males (MSM); b) Injection Drug Users; and c) Transgender Females Who Have Sex with Males (TGF/M).** Because testing data reported in medical settings does **not** include information on HIV transmission categories - key to two of our three prioritized populations - data in the table below is limited to **publicly funded HIV testing** in the three EMA counties over the specified period. This includes: a) HIV testing conducted in San Francisco community-based testing sites such as the Magnet Clinic in the Castro; b) HIV tests conducted by the San Francisco Department of

Health STD Program at public clinics; and c) all publicly funded testing conducted in San Mateo and Marin Counties.

Chart A. San Francisco EMA Newly Diagnosed Publicly Funded HIV Test Events January 1 - June 30, 2013			
Data Elements	**MSM**	**IDU**	**MTF/M**
▪ Number of test events	**9,155**	**836**	**235**
▪ Number of newly diagnosed positive test events[1]	**98**	**14**	**3**
▪ Number of newly diagnosed positive test events with clients confirmed as linked to medical care	**71**	**8**	**1**
▪ Number of newly diagnosed confirmed positive test events	**85**	**13**	**2**
▪ Number of newly diagnosed confirmed positive test events with client interviewed for Partner Services	**77**	**10**	**0**
▪ Number of newly diagnosed confirmed positive test events with clients referred to prevention services	**55**	**13**	**1**
▪ Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing and/or attended at least one confirmed medical care visit	**66**	**8**	**0**

Chart B. San Francisco EMA Previously Diagnosed Publicly Funded HIV Test Events January 1 - June 30, 2013			
Data Elements	**MSM**	**IDU**	**MTF/M**
▪ Number of test events	**9,155**	**836**	**235**
▪ Number of previously diagnosed positive test events	**54**	**6**	**3**
▪ Number of previously diagnosed positive test events with clients confirmed as linked to medical care	**22**	**1**	**1**
▪ Number of previously diagnosed confirmed positive test events	**48**	**5**	**1**

[1] 12 newly diagnosed HIV positive cases that were out of jurisdiction were excluded from these totals

Chart B. San Francisco EMA Previously Diagnosed Publicly Funded HIV Test Events January 1 - June 30, 2013			
Data Elements	**MSM**	**IDU**	**MTF/M**
▪ Number of previously diagnosed confirmed positive test events with client interviewed for Partner Services	**16**	**1**	**0**
▪ Number of previously diagnosed confirmed positive test events with clients referred to prevention services	**48**	**5**	**1**
▪ Total number of previously diagnosed confirmed positive test events who received CD4 cell count and viral load testing and/or attended at least one confirmed medical care visit	**66**	**8**	**0**

Overall, the data above indicates an extremely high seropositivity rate of **1.1%** among MSM who received testing at publicly funded sites in the city, not including individuals who tested positive at public clinics but who live outside the city. The rate among transgender women was even higher, at **1.3%**, and higher still among injection drug users, at **1.7%**. These percentages speak to the continuing impact of the HIV epidemic upon the highest risk populations identified in our FY 2013 EIIHA Plan. Overall, a total of **28,447** HIV test events were conducted in the San Francisco EMA in the six-month period from January 1 - June 30, 2013, with a total of **147** new HIV-positive individuals identified, for a total EMA-wide positivity rate of **0.52%**. Over **two-thirds** of all newly identified HIV positives were confirmed as having been linked to medical care (**99** of 147 new cases) and **78.2%** were interviewed for partner services (**115** of 147) - rates that speak to the success of our region in continually improving the rate at which individuals are linked to essential services and care following their initial diagnosis.

1.E.2) FY14 EIIHA Plan

Planned Activities of the San Francisco EMA EIIHA Plan for Fiscal Year 2014:

Estimate of HIV-Positive Individuals Who Are Unaware of Their Serostatus: The San Francisco EMA estimates that a total of approximately **3,339** individuals were infected with HIV but unaware of their serostatus as of December 31, 2012, representing **14.4%** of all persons currently estimated to be infected with HIV in our region. This figure was derived by calculating a proportion of persons with AIDS to persons with HIV of **1:1** based on consensus epidemiological estimated conducted in San Francisco in 2012. This calculation results in an estimated total of **23,164** persons living with HIV and AIDS in the EMA as of December 31, 2012, including persons who are unaware of their serostatus (see Attachment 3). The estimate of **3,339** HIV unaware individuals was then arrived at by subtracting the total of **19,825** confirmed persons living with HIV and in the EMA as of 12/31/12 from the total estimated HIV/AIDS population.

Target Populations for FY 2014 EIIHA Plan: To define and focus EIIHA activities in FY 2014, the following **three** populations will continue to serve as the key target groups for the FY 2014 San Francisco EMA EIIHA Plan:

1. **Males Who Have Sex with Males (MSM)**
2. **Injection Drug Users (IDU)**
3. **Transgender Females Who Have Sex with Males (TGF/M)**

Primary Activities to be Undertaken: The FY 2014 EIIHA Plan will encompass **four** broad activity areas which mirror those of the FY 2012 and FY 2013 Plans. These include: 1) Identifying individuals who are unaware of their HIV status and providing high-quality confidential and anonymous HIV testing to them; 2) Successfully informing individuals of their post-test HIV status and ensuring provision of confirmatory test results for persons who preliminarily test positive for HIV; 3) Providing timely, accurate, and appropriate referrals to HIV-positive individuals to facilitate access to culturally competent health, medical, and social service programs; and 4) Ensuring that HIV-positive individuals are successfully linked to essential medical and social services based on individual need. Specific activities to be undertaken through the Plan will be tailored to meet the needs of the Plan's three identified target population groups, with a particular emphasis on continuing to enhance systems to link newly identified HIV-positive individuals to care and to support them in remaining in care as they transition into acceptance of their HIV status.

Major Collaborations: As sister units in the San Francisco Department of Public Health AIDS Office, HIV Health Services works in close partnership with the Community Health Equity and Promotion Branch to plan services, design interventions, and share data and emerging findings. The new Disease Control and Prevention Branch, which oversees the LINCS program, is also a key collaborator. Through a strong working relationship, the three units are able to closely coordinate prevention and care planning and interventions with the goal of maximizing available resources and ensuring a seamless testing system in the EMA. The collaboration also aims to ensure non-duplication and non-supplantation of Ryan White Program funding. The collaboration is augmented with strong working relationships involving virtually all providers of HIV-specific prevention and care services in the EMA, as well as agencies serving high-prevalence populations at risk for HIV infection. With the new addition of San Mateo and Marin Counties to San Francisco's HIV prevention jurisdiction beginning in 2012, the ability to coordinate and scale up HIV testing across all counties has been greatly enhanced. Among the most visible outcomes of this expanded collaboration has been the publication of fully linked Jurisdictional HIV Prevention Plans for the EMA's three counties earlier this year.

The two SF County agencies and a broad range of related programs and services in the EMA operate through the region's **Continuum of HIV Prevention, Care, and Treatment** - a model developed through the current Enhanced Comprehensive HIV Prevention Plan (ECHPP) process and continued as part of core HIV prevention funding from CDC. The Continuum specifically focuses on **HIV testing, partner services, linkage, retention, re-engagement, and treatment adherence** and supports entry into and retention in care through sectors such as mental health services, substance abuse treatment, housing support, and medical case management (see chart below). The model also incorporates the Department's **Linkage Integration Navigation Comprehensive Services (LINCS) Program**, an innovative approach to care linkage and retention described in greater detail above.

Although not required by HRSA, in San Francisco, the HIV Health Services Planning Council is charged with coordinating both Part A and B and services to maximize the impact of these two funding streams. This service planning process is in turn coordinated with all units of the San Francisco AIDS Office, including the Community Health Equity and Promotion and the Disease Prevention and Control Branches, in order to enhance regional efforts to identify and

link to care persons with HIV who are unaware of their positive status. At the same time, representatives of agencies receiving funds through Ryan White Parts C, D, and F play an active role on the Planning Council to ensure integration and coordination of EIIHA activities with other Ryan White-funded services in the region. In late 2011, for example, the HIV Prevention Section provided extensive training on LINCS Team services to the HIV Health Services Planning Council, and has extended these training activities in 2012 to incorporate community care providers engaged in HIV testing and care linkage throughout our region.

The San Francisco EMA EIIHA system is designed to ensure that **any** door is the right door to HIV testing and treatment and that potential clients are able to access HIV services from any point in the EMA's health and social service network. To accomplish this outcome, the EMA has created extensive service partnerships and collaborations with providers across our region that are designed to link and integrate HIV prevention and care, and to create effective data and referral interfaces among public and private providers which enhance information-sharing and communication. The EMA has also strongly emphasized the need to work toward linking and merging the concepts of prevention and care and to eliminate arbitrary distinctions that can serve as barriers to planning and resource sharing and can unintentionally act as barriers to client entry into care.

To ensure a fully linked and coordinated system, planning meetings are held throughout the EMA involving the broadest possible range of provider groups to plan and develop systems for strengthening mutual information-sharing, support, and client linkage programs. A number of community planning bodies that incorporate extensive consumer participation – including the San Francisco HIV Health Services Planning Council and HIV Prevention Planning Council – help develop and enhance HIV access across systems, while ensuring that consumer voices and perspectives are incorporated into systemic and policy decisions. Meanwhile, County agencies are engaged in extensive provider outreach and education efforts designed to bring a greater level of participation, cooperation, and quality monitoring to the HIV programs of non-publicly funded organizations and entities.

Planned Outcomes of FY 2014 EIIHA Plan: The FY 2014 San Francisco EMA EIIHA Plan has **three** primary goals: 1) increase the number of individuals in Marin, San Francisco, and San Mateo counties who are aware of their HIV status; b) increase the number of HIV-positive individuals in our region who are effectively engaged in HIV care; and c) reduce disparities in regard to both HIV infection and HIV testing access. Specific objectives and activities through which progress toward these goals will be measured are described in greater detail in the population-specific section below.

It is particularly important to stress the fact that one of the most important aspects of HRSA's EIIHA initiative lies in its potential to significantly **reduce disparities** in HIV access and services for underserved HIV-infected populations. This is an outcome which mirrors one of the three central goals in the National HIV/AIDS Strategy for the US, to reduce HIV-related health disparities. By incorporating routine HIV testing in medical settings where under-served populations are seen, the EIIHA plan will reach many individuals who would not otherwise voluntarily seek or be offered HIV testing, including MSM of color, substance users, women, uninsured and economically impoverished populations, homeless persons, and young MSM – all populations that have experienced historical HIV access and treatment disparities along with high rates of late HIV testing. The San Francisco EMA will utilize its EIIHA plan and matrix to focus on increasing awareness of HIV status and promoting treatment utilization among underserved populations as a way to continue to address HIV-related health disparities.

How the FY 2014 Plan Contributes to the Goals of the National HIV/AIDS Strategy: The goals and objectives of the proposed FY 2014 EIIHA Plan continue to be fully consistent

with and contribute to the goals of the White House Office of AIDS Policy's National HIV/AIDS Strategy, including the Strategy's three primary goals of: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.[94] Our local EIIHA strategy is also fully consistent with HRSA's goal of making unaware individuals aware of their HIV status, particularly in terms of the strategy's aggressive approach to reaching and testing highly impacted HIV populations in the San Francisco EMA.

Relationship to Unmet Need Estimate and Activities: The FY 2014 EIIHA Plan responds to the EMA's annual unmet need process both prospectively and retrospectively. In a prospective sense, the EIIHA Plan seeks to significantly decrease the number of persons living with HIV/AIDS in the region who are unaware of their HIV status. This is particularly critical at a time when health care reform promises to usher in new options for increasing the number of low-income persons with HIV who are able to access affordable, high-quality health care coverage. Retrospectively, the EIIHA Plan utilizes unmet needs data to prioritize specific target populations on which to focus regional outreach, testing, and care linkage and retention activities and resources.

Planned Efforts to Remove Legal Barriers: Because of its long history of promoting, supporting, and carrying out aggressive HIV outreach, testing, and service linkage, the San Francisco EMA has developed strategies to address the few legal barriers to the expansion of routine testing in public and private settings. San Francisco has long offered routine HIV testing in county jail systems, for example, and has taken part in CDC-funded demonstration initiatives to test the effectiveness of opt-out HIV testing public hospital emergency rooms in San Francisco. The largest barrier to routine HIV testing – as in many regions – continues to center around financial barriers, including the relatively high cost of rapid HIV tests; the need for expanded personnel to effectively manage standardized or opt-out testing programs; and the need to implement and track quality indicators related to factors such as post-testing counseling and HIV service linkage. The San Francisco EMA continues to work to develop effective approaches to target resources to most effectively reach high-risk populations in the EMA.

Population-Level Barriers, Activities, and Objectives:

Why Target Populations Were Chosen: The three FY 2014 target populations were selected on the basis of **three** key factors. **First**, from an epidemiological standpoint, these three populations together encompass approximately **95%** of all persons currently living with HIV/AIDS in the San Francisco EMA. MSM alone - including MSM who inject drugs - alone make up **85.8%** of all HIV/AIDS cases in the region as of December 31, 2012, while non-MSM IDU make up another **6.9%** of all local PLWHA. **Second**, the populations represent the three groups most highly prioritized in the EMA's just-published Jurisdictional HIV Prevention Plans, which represent the product of intense study and collaborative planning. And **third**, the selected populations contain the highest rates of new HIV diagnoses as reported through HIV testing data for the period January 1 - June 30, 2013 (see testing table above).

Specific Challenges within the Target Populations: With the emergence of a new prevention paradigm in which broadly based community viral load suppression holds out the possibility of dramatically reduced rates of new HIV infections, additional challenges emerge that are equally salient. What standardized models of routine HIV testing are most appropriate for which health care settings, and what are the cost and capacity factors associated with these approaches? How can the San Francisco EMA best encourage regular, ongoing HIV testing among members of high prevalence populations, particularly when a negative test can sometimes be perceived as an indication that the individual is managing risk effectively? How will the ability to detect acute HIV more systematically as new technologies emerge, combined with the

local SFDPH universal offer of ARV treatment independent of HIV disease stage, impact system capacity? As more persons with HIV are identified, how can we ensure that these individuals are linked to care and do not fall through the cracks, particularly in a climate of diminishing resources? What are the long-term cost and capacity issues associated with bringing an expanded population into HIV care, particularly in light of the decades of medical and drug treatment support most of these individuals are likely to need? While the potential benefits of expanded HIV testing and care linkage are great, the challenges faced by systems and providers may prove to be commensurately daunting.

The San Francisco EMA faces a wide range of additional cultural, personal, and systemic barriers that continue to limit the number of persons from high-risk groups who seek and/or receive HIV antibody testing on a regular basis, many of which are common to large urban areas with concentrated HIV risk populations. Specific **priority needs** that obstruct awareness of HIV status among the EIIHA Plan's high-risk subpopulations include: a) growing complacency regarding the critical nature of HIV infection, including a belief that HIV infection has become a fully treatable condition with little or no morality risk; b) a lack of information regarding HIV risk among young people, including a lack of awareness of the importance of early intervention in the case of HIV infection; c) inadequate access to convenient and culturally appropriate testing or care services for youth, transgender persons, and women in abusive relationships; d) continuing widespread stigma related to both HIV infection and the behaviors that can transmit the virus; e) fear of having HIV status or behaviors exposed by service providers, including sexual and drug use behaviors; f) shortage of harm reduction-based approaches to HIV testing, care linkage, and treatment; g) fear among transgender persons of negative interactions between hormone therapies and HIV medications; and h) fear of deportation among undocumented immigrants.

Key **cultural issues** impacting HIV awareness in San Francisco include: a) dual discrimination faced by many MSM of color in regard to sexual orientation and ethnic background; b) threefold discrimination faced by many transgender persons of color in regard to gender identity, sexual orientation, and ethnic background; c) fear and mistrust regarding HIV drug treatment and the medical care system within communities of color; d) fear that HIV risk behaviors or sexual or gender orientation will be judged or stigmatized in culturally specific are and service systems; e) fear of discrimination based on ethnicity within HIV service agencies; f) shortage of culturally specific drug treatment programs for persons of color; and g) lack of programs that effectively address key issues underlying HIV risk behaviors and an unwillingness to seek testing such as persistent poverty, institutionalized discrimination, and childhood abuse and exposure to trauma.

Specific Activities to be Utilized With the Target Populations: The San Francisco EMA will employ a broad range of strategies to expand awareness of, access to, and utilization of HIV testing and care services in the service region, but for persons who are currently unaware of their HIV status and for persons with HIV who have dropped out of or become lost to care. The table beginning on the following page outlines these activities in relation to the three FY 2014 target populations. All activities listed in the EIIHA Plan will be coordinated with activities conducted by the HIV prevention units in the three EMA counties as outlined in the integrated jurisdictional HIV Prevention Plans. All activities will also be coordinated with the ongoing ECHPP process to promote HIV prevention and care integration in the region.

In addition to the activities listed on the chart below, San Francisco will also continue implementation of care access enhancement activities being made possible through the Center for Medicaid and CHIP Services **Delivery System Reform Incentive Pool (DSRIP)** and its **Category V** program specifically designed to enhance the capacity of participating hospitals to

develop programs to provide access to high-quality, coordinated, integrated care to patients diagnosed with HIV, particularly Low Income Health program (LIHP) enrollees who previously received services through Ryan White funding. The San Francisco DSRIP Category V program is being implemented at San Francisco General Hospital and is creating a range of specific HIV care enhancements, many of which are expected to expand the quality of care linkage and retention services in the region. This includes creation of a **model retention program** within patient-centered medical homes for persons with HIV, which began in April 2013 with a pilot program at San Francisco General Hospital for patients with high rates of missed primary care appointments as part of the ongoing PHAST program. The DSRIP pilot project aims to take best practices developed under the PHAST program that serves approximately **500** patients at high risk for non-linkage to care and apply them to the **3,000** patients followed in the hospital's HIV-specific Ward 86 clinic, with the goal of developing interventions to improve patient show rates for HIV primary care appointments. Through the DSRIP Category V program, extensive staff training programs are also being held throughout the hospital system to ensure care coordination within each medical clinic designated as a medical home for patients with HIV.

SMART Objectives for Each Target Population:

MSM:

1. Between March 1, 2014 and February 28, 2015, to provide a total of at least **19.000** documented HIV antibody tests for MSM in the San Francisco EMA.
2. Between March 1, 2014 and February 28, 2015, to identify a total of at least **190** new HIV-positive individuals within this population.
3. Between March 1, 2014 and February 28, 2015, to identify a total of at least **100** previously diagnosed HIV-positive individuals within this population.
4. Between March 1, 2014 and February 28, 2015, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
5. Between March 1, 2014 and February 28, 2015, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
6. Between March 1, 2014 and February 28, 2015, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
7. Between March 1, 2014 and February 28, 2015, ensure that at least **75%** accept partner services.

IDU:

8. Between March 1, 2014 and February 28, 2015, to provide a total of at least **1,750** documented HIV antibody tests for IDU in the San Francisco EMA.
9. Between March 1, 2014 and February 28, 2015, to identify a total of at least **20** new HIV-positive individuals within this population.
10. Between March 1, 2014 and February 28, 2015, to identify a total of at least **15** previously diagnosed HIV-positive individuals within this population.
11. Between March 1, 2014 and February 28, 2015, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
12. Between March 1, 2014 and February 28, 2015, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
13. Between March 1, 2014 and February 28, 2015, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
14. Between March 1, 2014 and February 28, 2015, ensure that at least **75%** accept partner services.

EIIHA Activities	Immediately or Already Implemented	To Be Implemented in FY 2014
Note that for all activities below the <u>timeframe</u> is 3/1/14 - 2/28/15 and the <u>parties responsible</u> are the San Francisco Community Health Promotion Branch, the San Mateo County HIV Prevention Section, and the Marin County HIV Prevention Unit.		
Males Who Have Sex With Males (MSM):		
▪ Create expanded testing opportunities in neighborhoods and venues frequented by MSM	**X**	
▪ Tailor HIV testing outreach specific to key MSM subpopulations such as MSM of color and young MSM	**X**	
▪ Utilize internet-based outreach to publicize testing among MSM	**X**	
▪ Employ social marketing strategies to encourage HIV testing at least every 6 months		**X**
▪ Expand mobile HIV/STD testing through mobile van and other approaches	**X**	
▪ Enhance utilization of partner services through LINCS	**X**	
▪ Utilize social networks to track and re-engage HIV-positive MSM who do not return for HIV test results	**X**	
▪ Create new approaches to normalize regular HIV testing among MSM of color and young MSM and improve return rates for HIV test results, including incorporating MSM programs and outreach into traditional health care settings	**X**	
▪ Utilize rapid testing in community settings and, where possible, in medical settings, to provide quick turnaround for results	**X**	
▪ Expand access to RNA and 4th generation HIV detection for high-risk MSM to diagnose and inform MSM of their HIV status as early as possible post-infection		**X**
▪ Utilize LINCS Team members to ensure rapid referrals to agencies that specialize in MSM health	**X**	
▪ Tailor referrals to meet the needs of MSM subpopulations such as MSM of color and young MSM	**X**	
▪ Incorporate MSM social support needs in referral decisions	**X**	
▪ Utilize LINCS Team members to make, verify, and track linkages to agencies that specialize in MSM health	**X**	
▪ Through LINCS Team members, provide ongoing, tailored, one-on-one adherence follow-up with newly diagnosed HIV populations for up to three months following initial HIV test	**X**	
▪ Continually expand network of private providers who utilize LINCS Team to ensure client linkage to care	**X**	
▪ Maximize existing available surveillance, clinical, and HIV testing data to track linkage to care process and ensure linkage occurs		**X**
Injection Drug Users (IDU):		
▪ Utilize drug-using networks of persons with HIV to identify IDUs for HIV testing	**X**	
▪ Utilize mobile testing strategies to reach IDUs in community and drug use venues	**X**	
▪ Ensure availability of HIV testing services in community drug and alcohol treatment facilities and syringe sites	**X**	
▪ Employ social marketing strategies to encourage HIV testing at least every 6 months		
▪ Enhance utilization of partner services through LINCS		**X**
▪ Provide continual training and re-orientation to HIV testing providers based in alcohol and drug treatment facilities	**X**	

EIIHA Activities	Immediately or Already Implemented	To Be Implemented in FY 2014
Note that for all activities below the <u>timeframe</u> is 3/1/14 - 2/28/15 and the <u>parties responsible</u> are the San Francisco Community Health Promotion Branch, the San Mateo County HIV Prevention Section, and the Marin County HIV Prevention Unit.		
▪ Develop more effective systems for tracking down and locating homeless IDUs for disclosure of test results	**X**	
▪ Utilize social networks to track and re-engage HIV-positive IDU who do not return for HIV test results		**X**
▪ Apply a harm reduction approach to IDU testing and care linkage	**X**	
▪ Utilize rapid testing in community testing settings and, where possible, in medical settings, to provide quick turnaround for results	**X**	
▪ Utilize LINCS Team members to provide comprehensive referrals appropriate to IDU populations	**X**	
▪ Ensure referral to Hepatitis C testing and treatment information if not offered at the HIV testing venue	**X**	
▪ Prioritize immediate referrals to individual risk reduction counseling for active injection drug users.	**X**	
▪ Utilize LINCS Team members to make, verify, and track linkages to agencies that specialize in IDU services	**X**	
▪ Through LINCS Team members, provide ongoing, tailored, one-on-one adherence follow-up with newly diagnosed HIV populations for up to three months following initial HIV test		**X**
▪ Continually expand network of private providers who utilize LINCS Team to ensure client linkage to care	**X**	
▪ Maximize existing available surveillance, clinical, and HIV testing data to track linkage to care process and ensure linkage occurs	**X**	
Transgender Females Who Have Sex With Males (TGF/M)		
▪ Utilize transgender female peer leaders to generate support for HIV testing through social support networks	**X**	
▪ Utilize mobile testing strategies to reach transgender females in community and sex worker venues	**X**	
▪ Employ social marketing to encourage HIV testing at least every 6 months		**X**
▪ Enhance utilization of partner services through LINCS	**X**	
▪ Provide expanded training in transgender female needs and best practices to private HIV testing providers;	**X**	
▪ Utilize transfemale social networks to locate HIV-positive TGF/M who have not returned for test results	**X**	
▪ Pre-schedule return HIV testing visits every 3 to 6 months depending on risk at time test result is delivered	**X**	
▪ Utilize rapid testing in community and medical settings, to provide quick turnaround for results	**X**	
▪ Utilize LINCS Team members to ensure referrals to agencies that specialize in transgender health	**X**	
▪ Provide referral to Hepatitis C testing for transgender females who have used needles to self-administer hormones	**X**	
▪ Incorporate transgender social support and mental health needs in service referral recommendations.	**X**	
▪ Utilize LINCS Team members to make, verify, and track linkages to care and treatment agencies that specialize in transgender health or that have a demonstrated history of providing sensitive and appropriate transgender care	**X**	
▪ Through LINCS Team members, provide ongoing, tailored, one-on-one adherence follow-up with newly diagnosed HIV populations for up to three months following initial HIV test	**X**	

Transgender Women Who Have Sex with Men:

15. Between March 1, 2014 and February 28, 2015, to provide a total of at least **480** documented HIV antibody tests for transgender women who have sex with men in the San Francisco EMA.

16. Between March 1, 2014 and February 28, 2015, to identify a total of at least **5** new HIV-positive individuals within this population.

17. Between March 1, 2014 and February 28, 2015, to identify a total of at least **6** previously diagnosed HIV-positive individuals within this population.

18. Between March 1, 2014 and February 28, 2015, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.

19. Between March 1, 2014 and February 28, 2015, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.

20. Between March 1, 2014 and February 28, 2015, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and

21. Between March 1, 2014 and February 28, 2015, ensure that at least **75%** accept partner services.

Responsible Parties and Collaborations: Implementation and evaluation of the FY 2014 EIIHA Plan will be the joint responsibility of San Francisco HIV Health Services, the San Francisco Community Health Equity and Promotion Brach, and the San Francisco Disease Prevention and Control Branch, with the close collaboration of the San Francisco care and prevention planning bodies and prevention and care staff in Marin and San Mateo Counties. County staff will continually collect data related to HIV testing, service linkage, and other follow-up activities for each of the target populations and will regularly report this information to the State of California and will summarize the data in regular reports to HRSA as required. Additionally, the EMA's three counties will collect information on specific enhancements and service activities brought about through the EIIHA Plan and will report these activities to HRSA as required. Modifications to the EIIHA Plan made during the 2014 Part A fiscal year will be jointly approved by the three counties and discussed and approved by the EMA's prevention and care councils.

Planned Outcomes: The proposed FY 2014 EIIHA strategy will continue the work of the San Francisco EMA to expand and enhance awareness and utilization of HIV testing throughout the region for the project's three key populations, while increasing utilization of care and prevention services and promoting greater adherence to HIV treatment services.

Plan to Disseminate EIIHA Plan and Outcomes: As a document jointly developed by HIV Health Services and the Community Health Promotion Branch, the FY 2014 EIIHA Plan will be shared with both the San Francisco Health Services Planning Council - the Ryan White Part A oversight body - and the San Francisco HIV Prevention Planning Council. The EIIHA Plan will also be shared with prevention staff of both Marin and San Mateo counties. Ongoing progress related to EIIHA action steps will be extensively reported to the Planning Council and the Prevention Council with the goal of refining and helping shape future EIIHA action plans and strategies. Model interventions and programs developed through the EIIHA program will be broadly disseminated and shared among public and private providers throughout the San Francisco EMA, including through trainings developed and presented to community-based HIV providers and public and private medical providers. The San Francisco EMA may also publish best practice documents or guidelines related to specific aspects of the outreach, testing, and

linkage enhancement initiative, and/or develop and conduct trainings for local agencies and staff on demonstrated methods for enhanced EIIHA-related planning and program implementation.

WORK PLAN

1) Access to HIV/AIDS Care and the FY 2014 Implementation Plan

1.A) Continuum of Care for FY 2014

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

Throughout the San Francisco EMA, the emphasis on **high-quality, client-centered, and culturally competent primary medical care services** remains at the heart of the local care continuum, with **medical case management** offering individualized assessment, coordination, and linkage to a full range of social and supportive services. In addition to a number of major hospitals in the EMA, there are seven public clinics and six community clinics in San Francisco County; two public clinics in San Mateo County; and one public clinic in Marin County providing HIV/AIDS primary care. In Marin County, cases and services are focused around the major cities bordering the north-south-running Highway 101. San Mateo County has one HIV epicenter along its border with San Francisco and another at the opposite end of the county adjacent to East Palo Alto, with services spread between them. All non-medical Ryan White-funded providers are trained to refer persons with HIV to **any** primary care site in the region.

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

care linkage services are supported through non-Part A funding streams, many directly linked to the new Centers of Excellence.

Helping Individuals Access and Remain in Care: The primary challenge of Part A-funded agencies in the current fiscal environment is to stabilize peoples' lives so that they can access care on a more consistent basis, while continuing to provide comprehensive, quality care for those whose lives remain chaotic. An increasing proportion of those affected by HIV in the region are members of **emerging** and increasingly large **multiply diagnosed populations** who face a broad range of co-morbidities such as homelessness, poverty, mental illness, substance addiction, recent incarceration, and/or a range of additional health and life complications, including the effects of aging with HIV. San Francisco's integrated services programs have been highly successful in bringing such hard-to-reach clients into care and helping them manage medication regimens and remain engaged in care. However, many programs providing specialized support services focused on hard-to-reach populations have been **de-funded** as a result of Part A funding cuts in our EMA from FY 2003 through FY 2009 - cuts made just at the time when those services are most urgently needed.

The San Francisco EMA operates a wide range of outreach, care linkage, and treatment access activities to reach severe need populations, some of them supported through **MAI funding**. Marin County, for example, has co-located testing, primary care, social services, and research programs in one central facility to provide easier access to service for residents, while the San Francisco HIV Prevention Section has funded a new full-time linkage specialist to concentrate on linking newly tested positive persons with counseling and care. San Mateo's Health Outreach Team travels throughout the county providing outreach, peer support, triage, referrals, and transportation to appointments. The emphasis of all of these programs is on ensuring that disenfranchised and underserved HIV-infected persons learn about their HIV status; become informed about the system of care; and receive the support they need to access services on a long-term basis. These programs are also linked and integrated with our EMA's existing matrix of EIIHA services, designed to identify and bring into care as many new HIV-infected individuals as possible.

Additional Part A-funded components of the EMA's system of care increase clients' ability to access service and increase their self efficacy with regard to remaining engaged in 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 probability 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. 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.

The San Francisco EMA's Centers of Excellence (CoE) network has also successfully forged a new type of "safety net" for severe need and special populations based on the medical home model, one that encompasses a range of populations and neighborhoods and that is making a major contribution to the EMA's goal of reducing disparities and improving access to care for hard-hit and underserved communities. Through the CoE program, the **Mission Center of Excellence**, **Native American Center of Excellence**, and **Southeast Partnership for Health** provide culturally competent services for three key hard-hit populations of color in our region: Latinos/Hispanics, Native Americans, and African Americans, respectively. Meanwhile, the **Women's Center of Excellence** provides a unique range of services specifically tailored to

the needs of HIV-positive women, while the **Tenderloin Area Center of Excellence** offers services to homeless and marginally housed individuals, as well as active substance users, transgender persons, and - through a partnership with Asian & Pacific Islander Wellness Center - Asian/Pacific Islander communities. The services of the **Forensic AIDS Project** provide unique incarceration-based outreach, service, and post-release follow-up to persons in San Francisco County Jails. The transitional Case Management Program (TMP) funded by the California Department of Corrections supports inmates' transition from the prison system back into the community by linking them with medical and support. All CoEs also incorporate prevention with positives interventions (PWP) into their care services and all are fully linked to the regional HIV counseling and testing network. The **Women's Centers of Excellence**, for example, incorporates an innovative PWP program for women and male-to-female transgender people called the **Sexual Health and Empowerment Program (SHE)**, an intervention incorporating formal risk assessments; one-on-one counseling with on-site Prevention Coordination; and ongoing risk-reduction groups and other services, including sexual and IDU harm reduction seminars, support, and referrals. The chart below outlines the names and functions of the seven CoEs currently operating in our EMA (see Figure 13).

Figure 13. Chart of San Francisco EMA Centers of Excellence (CoEs)

Name of CoE	Lead Agency	Location(s)	Target Populations
Chronic Care HIV/AIDS Multidisciplinary Program Center of Excellence (CCHAMP CoE)	University of California San Francisco	Mission / Potrero Hill District (San Francisco General Hospital) &. Clinics in South of Market, Upper Van Ness, & Castro	Medically complex MSM, Latino, African American, transgender, women, persons 50 years and over, immigrants & Spanish-speaking
Forensic AIDS Project	San Francisco Department of Public Health	Six San Francisco County Jails with an average daily census of 2,200 prisoners	Incarcerated persons both in jail and post-release
Mission Center of Excellence	Mission Neighborhood Health Center	Mission District	Latino/Latina populations, including monolingual Spanish speakers, and immigrants
Native American Center of Excellence	Native American Health Center	Medical care in Mission District	Native Americans and Alaska Natives, including male, female, and transgender
Black Health Center of Excellence	University of California San Francisco	Citywide and Bayview / Hunters Point / South of Market / Western Additions	Underserved & severe need African American populations
Tenderloin Area Center of Excellence	Asian & Pacific Islander Wellness Services	Tenderloin District	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 Western Addition	Underserved and severe need women, including transgender women

1.B) FY 2014 Implementation Plan Table - See **Table** in **Attachment 7**.

1.C) FY 2014 Implementation Plan Narrative

1) <u>Linking Needs Assessments, Plans, and Service Priorities:</u> The FY 2014 Ryan White Part A Implementation Plan for the San Francisco EMA is an innovative, client-centered, and cost-effective strategy for meeting the most critical care and support needs of HIV-infected individuals with low incomes in the region. The FY 2014 Plan also urgently seeks to restore at least some share of the Part A dollars that have been lost to the EMA over the past decade. At a time of rising costs, declining resources, and expanding HIV-infected populations, the Plan seeks the restoration of essential support to allow the EMA to continue to ensure a seamless, comprehensive, and culturally competent system of care focused on the complementary goals of: **a) reducing inequities and disparities** in HIV care access and outcomes, and **b) ensuring parity and equal access** to primary medical care and support services for all residents in the 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 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 described below. **The FY 2014 Part A Implementation Plan represents a balanced and effective strategy to both preserve and advance a tradition of HIV service excellence in the San Francisco EMA.**

The FY 2014 Part A Implementation Plan is also fully linked and integrated with the goals and objectives of the 2012 - 2014 Comprehensive HIV Services Plan for the San Francisco EMA, published on May 15, 2012. The FY 2014 Implementation Plan - combined with the EIIHA activities outlined above - directly responds to **all five primary service goals** of the Comprehensive Plan, consisting of the following:

- **Goal # 1:** To ensure a client-centered, coordinated, culturally competent continuum of essential services for all Ryan White-eligible persons with HIV, including emerging populations, persons experiencing health disparities, and persons with severe needs.
- **Goal # 2:** To identify, link, and retain in care HIV-aware Ryan White-eligible persons who are not currently in HIV care.
- **Goal # 3:** To identify, link and retain in care Ryan White-eligible persons with HIV who are unaware of their HIV status.
- **Goal # 4:** To expand coordination and collaboration with relevant funding streams and programs throughout the EMA to maximize resources and ensure that Ryan White funds are used as the funding source of last resort.
- **Goal # 5:** To research, plan for, and respond to changes to the Ryan White system resulting from the Affordable Care Act (ACA) and other healthcare access initiatives to ensure that Ryan White funds are used as the funding source of last resort.

The FY 2014 Part A Implementation Plan requests a total of **$36,218,233** in Formula and Supplemental funding to allow the SF EMA region to continue to meet escalating client needs in an effective and strategic manner. Direct service allocations make up **94.1%** of this total request, for a total of **$34,062,321**. Another **$350,000** supports EMA-wide quality management activities while **$1,805,912** supports administrative costs for the Grantee at the stipulated **5%** level, including San Francisco Planning Council expenses. Reflecting HIV caseload proportions in the EMA's three counties, a total of **8.5%** of the FY 2014 direct service request supports HIV client

services in **San Mateo County**, while another **3.5%** supports direct HIV services in **Marin County**. The remaining service allocation supports persons living with HIV and AIDS in the City and County of San Francisco.

As noted above, the FY 2014 Plan is **fully linked and integrated** with all key data sources, documents, and service plans for the region, including: a) the EMA's new 2012-2014 Comprehensive HIV Health Services Plan; b) the most recent San Francisco EMA HIV Health Services Needs Assessment; c) Qualitative Follow-Ups to the Needs Assessment; d) the 2008 Centers of Excellence Analysis; and e) a range of additional data reports prepared for the 2014 prioritization and allocation processes that describe specific critical needs and populations within the local system of care (see Methodology Section 1.B above).

2) Support for HRSA Core Services: The vast majority of proposed FY 2014 service expenditures – **76.53%** of total requested service dollars (**$26,066,533**) - support the provision of direct care services in HRSA-identified **core service categories**, above the minimum 75% core services level required**.** Of this year's total direct service request, a total of **$13,737,659** is requested for **outpatient / ambulatory health services** (including **$587,966** in Part A MAI funds), an amount representing **52.7%** of the total core services request and **40.3%** of the total FY 2014 direct service budget. This category includes support for ambulatory care services delivered in community and institutional settings as well as the **seven regional Centers of Excellence** that build upon and enhance San Francisco's highly successful integrated services approach to care. Additional HRSA core categories for which funding is requested in the FY 2014 Plan include: a) **Mental Health Services,** including Crisis and Outpatient Mental Health Services (**$2,952,181**); b) **Medical Case Management** that links and coordinates assistance from multiple agencies and caregivers in order to ensure access and adherence to medical treatment (**$3,055,050,** including **$224,994** in requested MAI funds); c) **Hospice Services** supporting room, board, nursing care, counseling, physician services, and palliative care for clients in terminal stages of illness (**$2,564,212**); d) **Oral Health Care** to address critical dental manifestations of HIV and preserve overall client health (**$1,700,050**); and e) **Home Health Care** to meet direct medical treatment needs outside of inpatient and clinical settings (**$998,707**).

As a result of Planning Council decisions, funding is **not** requested for several core medical service categories, including ADAP Treatments, Health Insurance Premium and Cost Sharing Assistance, and Medical Nutrition Therapy. In terms of pharmaceutical assistance, the State of California has long maintained one of the strongest and most comprehensive ADAP programs in the US, and because of the EMA's success in reaching Medi-Cal eligible populations and enrolling them in care, the EMA is not seeking Part A funds in this category.

3) Providing Access to the Continuum of Care for Minority Communities: Communities of color represent the fastest-growing HIV-infected groups in San Francisco, and include a high percentage of **multiply diagnosed, hard-to-reach, and severe need clients,** who require intensive support to stabilize their lives and enter and remain in care. The EMA's Centers of Excellence (CoE) program is designed to specifically address this crisis. Initiated in November 2005, the three-part goal of the CoE 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 care. The program is also designed to address **rising costs** associated with care for multiply diagnosed and complex populations by creating single-source points of contact in which services can be streamlined and economies of scale realized.

San Francisco's Centers of Excellence have already achieved significant success in enrolling greater numbers of persons of color with low incomes and severe needs in medical care services, with persons of color making up **71.0%** of all Centers of Excellence clients versus **52.7%** of the total Ryan White population. Even more striking has been the increase the CoEs have been able to achieve among **African American** clients, who now make up **30.6%** of the CoE client population as compared to **19.3%** of the Ryan White system as a whole.[95]

4) <u>Addressing the Needs of Emerging Populations:</u> Both the FY 2014 Implementation Plan and the 2012-2014 Comprehensive HIV Services Plan are designed to allow the SF EMA to reach and serve members of **all** emerging populations in the region. Part A-funded programs address the complex needs of groups that have traditionally been disenfranchised from the health care system, including people of color, men of color who have sex with men, injection drug users, transgender persons, recently incarcerated persons, and the homeless. The program's emphasis on **medical case management** allows for the coordination of client medical needs and for the provision of treatment adherence services to help persons with severe and multiple needs remain compliant with complex medication therapies. A focus on **mental health** and **outpatient substance abuse** services in all CoE programs allows for the stabilization of diverse groups facing chemical addiction and psychological challenges, including homeless men and women, injection drug users, formerly incarcerated persons infected through IDU, and young people.

The Centers of Excellence program provides a special opportunity for emerging populations to enter and remain in care. The Centers are designed specifically to serve **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. Additionally, the CoEs are also designed to serve **special populations**, defined as those that face **unique or disproportionate barriers to care,** such as individuals with linguistic or cultural barriers, individuals released from incarceration settings, and transgender individuals. San Francisco also continues to incorporate new approaches to HIV care for aging populations through the multidisciplinary approach of programs such as the **Chronic Care HIV/AIDS Multidisciplinary Program Center of Excellence (CCHAMP CoE),** operated by the University of California San Francisco, which is developing models of integrated, comprehensive care that incorporate geriatric medicine and specialty care with HIV services.

5) <u>Encouraging PLWHA to Remain in Primary Care and Adhere to HIV Treatments:</u> The San Francisco HIV service system ensures that comprehensive treatment education, adherence, and support services are incorporated into **all** Part A-funded primary medical care and case management programs, and that client contact staff receives ongoing education in helping clients remain in care and, if indicated, on treatment. The EMA's model of **medical case management,** for example, is 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 innovative approach taken by the SF EMA – is proving to be particularly successful in increasing the effectiveness of case management services for **multiply-diagnosed clients with severe needs**. Our FY 2014 Part A funding request includes support for **36,700** units of integrated medical case management service that will reach at least **3,100** unduplicated high-need individuals who require these services in order to access and remain in medical care. Support for **mental health services** is also critical in helping persons with HIV - including those with severe

and persistent mental illness - identify and address key psychosocial issues and attain and preserve the stability needed to remain medication adherent, including through the prescription and monitoring of psychotropic medications. The FY 2014 Part A funding request seeks support for **22,500** units of **outpatient mental health** services providing mental health treatment and counseling services to an estimated **1,950** unduplicated persons with HIV.

6) 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 ensure access to high-quality care across our region. The EMA places a strong emphasis on **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 accessibility within hard-hit communities and neighborhoods. The region has also 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, incarceration status, and HIV-related stigma. The FY 2012 Part A Plan, for example, includes **$1,132,332** in support of **non-medical case management services.** Non-medical case management includes intensive benefits counseling and money management services to ensure that hard-to-reach populations such as homeless and multiply diagnosed persons, low-income women, and persons who are out of care have the same ability to access consistent care and that they are able to maximize the limited financial resources at their disposal. Another approach to ensuring parity involves the creation of Centers of Excellence specific to disproportionately affected populations such as the Black Center of Excellence, the Mission Center of Excellence, the Women's Center of Excellence, and the Native American Health Center, which provide specialized services to promote parity of service access among Latino, female, and Native American populations, respectively.

7) Ensuring Culturally and Linguistically Specific Services: As noted above, the EMA's Centers of Excellence model has proven to be a highly effective approach to ensure access to culturally and linguistically appropriate services in the culturally and linguistically diverse San Francisco region. Because CoEs are tailored to the needs of specific ethnic and cultural populations and are operated by community-based minority agencies in the neighborhoods in which targeted populations live, they are able to ensure a uniquely high level of cultural competence. This competence goes beyond merely transposing traditional care approaches for emerging populations, but consists of a **top-to-bottom re-envisioning of HIV services** to ensure that Part A care is appropriate, syntonic, and responsive to communities of color. CoE such as the Mission Center of Excellence, the Black Center of Excellence, and the Native American Health Center of Excellence are specifically directed to communities of color, and offer culturally appropriate care in safe, welcoming settings. The Tenderloin Area Center of Excellence - through a partnership with Asian & Pacific Islander Wellness Center - provides services in a number of Asian / Pacific Islander languages including Cantonese, Vietnamese, and Tagalog. San Francisco HIV Health Services also includes cultural competence standards and quality measures in Part A contracts, and conducts training and technical assistance throughout the region to ensure the cultural and linguistic appropriateness of services provided through Ryan White funds. In addition, the San Francisco Planning Council has provided funds for the EMA's **HIV Resources Guide** as a way to enhance access to culturally competent services.

8) Relationship and Correspondence with Healthy People 2020: San Francisco EMA Part A services are fully compatible with the goals and objectives of the U.S. Department of

Health and Human Services' *Healthy People 2020* document, the nation's overarching health plan. [96] The vast majority of HIV-specific objectives contained in *Healthy People 2020* are focused on EIIHA-related **HIV testing and linkage to care** objectives, as opposed to objectives more specifically focused on Part A goals such as retaining persons with HIV in care; helping them remain adherent to medications, in part by stabilizing the conditions of their lives; and ensuring support for the cost of HIV medical care and treatment on an ongoing basis. The most specific relevant objectives of *Healthy People 2020* reflected in our region's Comprehensive Plan and by our FY 2014 Part A funding plan are: a) **HIV-11:** Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS; and b) **HIV-12:** Reduce deaths from HIV infection.

9) <u>Ensuring Proportional Funding for Women, Infants, Children, and Youth:</u> Resource allocations for women, infants, children, and youth (WICY) in FY 2014 are more than proportionate to the percentage of local HIV/AIDS cases represented by these populations. **As noted above, according to the CDC, the San Francisco EMA has by far the lowest percentage of women, infants, children, and youth (WICY) living with HIV/AIDS through 2010 of any EMA or TGA in the nation, with WICY populations making up only 7.96% of local PLWHA.**[97] The region's extremely low WICY percentage reflects the continuing disproportionate impact of the local HIV epidemic on men who have sex with men and injection drug users, as well as the relatively small percentage of children living in the city and county of San Francisco. However, while women account for **6.5%** of persons living with AIDS in the EMA, they make up **11.7%** of all individuals receiving local Ryan White-funded services and **fully 21.7% of all clients receiving services through the region's Centers of Excellence program**. Meanwhile, while infants, children, and youth 24 and under make up **1.5%** of the total PLWA population, they account for **2.4%** of local Ryan White clients. The percentage of Ryan White dollars spent to provide care for these populations is in proportion to these populations' representation in the local Ryan White system, reflecting both the high needs of these populations and the region's success at bringing them into care. The EMA works to ensure that local services are also **culturally responsive and effective** for women and young people, who make up a significant share of those whom the Centers of Excellence program assists.

10) <u>Using MAI Funding to Enhance Quality of Care:</u> 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 the region. FY 2012-2014 Part A MAI funding has enabled the EMA to serve **over 400** impoverished clients of color, many of whom are transgender people. Perhaps the most significant way in which MAI funds ensure quality care access for communities of color is through funding of the **Mission Center of Excellence** that has been established in the heavily Latino Mission district by **Mission Neighborhood Health Center.** The Mission CoE addresses what is both the fastest growing and one of the most highly impoverished communities in San Francisco in terms of HIV infection. Over the most recent 24-month period alone, the percentage of Latinos living with HIV/AIDS in the EMA grew from **15.5%** of PLWHA to **18.0%** of PLWHA, while Latinos represented **21.6%** of all new AIDS cases identified from 2010 through 2012. According to the Pew Research Center, **29%** of Hispanics in California lack any form of health insurance and **25%** of Hispanics 17 and under live below the Federal Poverty Line.[98] The **Mission Center of Excellence** provides culturally competent, integrated, bilingual/bi-cultural medical and health services to community members living with HIV, with an emphasis on Spanish-speaking Latino clients. In addition to

supporting the cost of direct medical / ambulatory health services through a staff of five bilingual / bicultural professionals, MAI funding also helps support the cost of medical case management, psychiatric, treatment adherence, and mental health services. MAI-funded peer and treatment advocates also help clients make informed decisions about medications, and work with them to identify and remove barriers to adherence.

11) Incorporation of Unmet Need Data: The Planning Council reviewed a summary estimate of unmet need among PLWA and PLWHA 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. Both the 2008 Comprehensive Needs Assessment and the 2010 Qualitative Update also included a significant emphasis on assessing unmet HIV service needs specifically, yielding critical information that was used by the Council in its prioritization and allocation process. This included information ranking Part A service categories in terms of those most utilized and most needed by PLWHA, along with recommendations for addressing gaps in service delivery to ensure a more comprehensive system of care. Key unmet needs findings contained in the 2008 assessment, for example, included recommendations to: a) increase the availability of substance use services for PLWHA; b) enhance transportation services for severe need clients; c) explore potentially effective pharmaceuticals that are not currently included in the California ADAP formulary; and d) address housing disparities in regard to race and ethnicity.

12) Addressing the Need for HIV Medications: The Planning Council intensely considered potential shortfalls in medication support which could necessitate new or expanded utilization of Part A funds for this purpose. Among other data, the Council considered information on ongoing ADAP funding in California; financial data regarding support for HIV medications purchase through Medi-Cal, Medicare, and other key local reimbursement sources; reports from providers regarding pharmaceutical needs; and the potential of health care reform measures to ease the burden on the State ADAP system by expanding reimbursement for HIV medications through expanded low-income health coverage. As a result of this input, the Council made the decision to continue funding viral resistance testing in the EMA - a procedure that had previously been funded through Ryan White Part B ADAP - while continuing to **not** request direct Part A funds for the purchase of HIV pharmaceuticals.

13) Consideration of EIIHA Population Groups: The key target populations identified in the EIIHA Plan closely correspond to the emerging populations which are a special focus of Part A funding in the EMA through the nationally respected Centers of Excellence program. The Council continually considered data and input regarding the needs of EIIHA population groups, including both service needs and the need to increase the proportion of HIV-infected populations within these groups who are aware of their HIV status and effectively linked to care.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

1. CLINICAL QUALITY MANAGEMENT

1.A) Description of Clinical Quality Management Program

1.A.1) CQM Plan and Infrastructure

Overall Purpose and Goals of the Quality Management Program: The San Francisco EMA operates a dynamic, multi-tiered **Quality Management Program (QMP)** designed to ensure the highest quality of care, outcomes, and cost-effective services for local consumers that **greatly exceeds** HRSA HAB expectations. The Quality Management Program incorporates **two** critical methodologies: **a) Quality Assurance** and **b) Quality Improvement**. Quality Assurance

(QA) consists of measuring compliance to minimum quality standards and pinpointing specific problems to be resolved. Quality Improvement (QI) is the continuous modification of processes or systems to improve outcomes for all parties involved and all consumers served. By integrating these methodologies, the SF EMA is able to continuously achieve maximum quality service provision and outcomes.

The underlying approach to quality management is based on the principle of **process improvement** and involves a dedicated quality management team that provides ongoing monitoring of all quality activities within the EMA. The basic goals of the QM system are threefold: 1) To ensure continuous, accurate electronic data collection and analysis of Ryan White-funded services in the SF EMA through the region-wide AIDS Regional Information and Evaluation System (ARIES) database for Part A-funded services; 2) To reliably track progress toward established markers and milestones that are indicative of the quality of service provided; and 3) To continually improve and enhance client service practices and outcomes through accurate and timely service data. To achieve these results, the program incorporates a range of QM components, including the following:

- **Data Management Standards and Compliance:** The San Francisco EMA utilizes the **AIDS Regional Information and Evaluation System (ARIES)** to collect programmatic and client-level data from Ryan White funded providers. ARIES is a comprehensive data registry system that has served as a national model for collection of client-level data. San Francisco provides comprehensive assistance to contracted Part A and B agencies in data compliance and technical support for ARIES, including data and quality management performance indicators for clients receiving HIV services. Data management reports are reviewed on a **monthly basis** to ensure that subcontractors are meeting client-level and service data compliance requirements. Agencies with incomplete or missing client or service level data are identified and correction plans are developed to rapidly address and solve data problems.
- **Standards of Care and Best Practices for HIV Service Delivery:** The San Francisco EMA has developed Standards of Care for **all** Ryan White service categories, and **five** best practices documents have been completed and disseminated to guide care quality in our region, including best practices for Centers of Excellence, transgender individuals, people of color, prevention with positives, and linkages from HIV testing to care.
- **HIV Provider Training Program:** The EMA's comprehensive provider training program offers service category standards of care orientations and specialized workshops on a wide range of subjects such as HIV Treatment Updates, Client De-Escalation, Professional Boundaries, Multidisciplinary Case Conferencing, and Transgender Cultural Competency. Beginning in May 2006, the EMA also initiated a new **Community Based Organization Capacity Building Training Series** funded through the US Office of Minority Health designed to build the capacity and effectiveness of community of color agencies, covering topics such as Supervision and Management Best Practices. Provider trainings allow for focus on skills-building in direct client care and on infrastructure issues related to sustaining viability in the face of expanding populations and declining resources.
- **Technical Assistance and Program Evaluation:** Technical assistance is a vital component of the QM program. TA efforts have focused on improving the quality of client care provided by our agencies, including multidisciplinary case conferencing; effective management of client records; chart reviews; and integrating health outcome data into service delivery design. Local Ryan White agencies are able to request technical assistance at any time, and

staff of HIV Health Services provides on-site assessment of needs and assignment of qualified support personnel, including staff and assigned consultants.

- **Health Outcomes and Indicators for Core Services:** The development and tracking of measurable health outcomes as a result of services rendered by Ryan White providers is an ongoing focus of the regional 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.

The Quality Management Program Consultant, who contracts directly with the City of San Francisco, is monitored annually by SF DPH 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 by the Consultant to assist HHS staff in monitoring program achievements. The Quality Management Consultant works closely with HHS to ensure that quality management activities are planned and coordinated in a manner consistent with HRSA requirements. The Consultant is also responsible for monitoring the timely completion of duties by all project sub-consultants under her supervision on a monthly basis. The Director of HIV Health Services provides ongoing monthly updates and information on quality management activities to the San Francisco HIV Health Services Planning Council. The Quality Management Program Consultant and the HIV Health Services Data Systems Administrator also provide regular formal progress reports to the Council on the status of the quality management program and the client-level data system. The Planning Council is notified of the quality management training schedule and is invited to attend workshops. Evaluations are also completed for all trainings and an annual training progress report is submitted to HIV Health Services to monitor and improve the training component.

Within the San Francisco EMA, client-level data is collected and entered by providers into **ARIES**, the system-wide shared client database to which all San Francisco Ryan White agencies are now linked. The system collects a range of client-level data, from basic demographic information to medical data fields depending on each program's service modality. The data compliance standard is **95% completion for all required data fields**. Since August 2004, **all** Part A direct service contractors have been required to provide client-level data as a condition of award and an ongoing pre-condition for receipt of payment for services delivered. In addition, provider invoice data (UOS and UDC) **must** match ARIES service line item data.

Outcome indicators for the San Francisco Centers of Excellence include a total of **eight** separate primary medical care outcomes related to factors such as ARV therapy management and adherence; HIV staging and monitoring; Viral Load Testing and Suppression; 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 Centers of Excellence 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.

Roles of Staff and Committee Members and Allocated Resources: The San Francisco EMA maintains a well-established Quality Management infrastructure that enables consistent analysis and problem solving of issues related to client care. Within the SF EMA, **1.4%** of Ryan

White funding is allocated annually to carry out the region's QMP activities. The **Director of HIV Health Services,** Bill Blum, oversees the creation, implementation, and evaluation of QI activities that are in turn supervised and managed on a day-to-day basis by the **QI Coordinator.** Under these individuals' supervision, and in collaboration with local providers, quality management components are developed and implemented by the **Quality Management Program Coordination Consultant** who works in collaboration with the **HIV Health Services Data Systems Administrator** and other HIV Health Services staff to develop and implement new or enhanced QM programs. Additional consultants with a range of diverse skills and expertise support the QM program through the provision of services such as training, technical assistance, program evaluation, and administrative support. Meanwhile, the SF EMA **Quality Improvement Committee**, comprised of members with diverse perspectives on quality of care, is responsible for annual updating of the Quality Management Plan; prioritizing and implementing QI projects; providing continuous QI and topical training; responding to providers' needs by utilizing the National Quality Center's (NQC) modules and tools; and updating performance indicators to satisfy quality measures. The chart below briefly outlines responsibilities of staff and committees involved in the EMA's quality improvement effort:

Chart of Responsibilities for SF EMA Clinical Quality Management Program	
Individual / Entity	**Role / Responsibilities**
▪ **HHS Interim Director**	▪ Provides fiscal oversight; approves overall plan; reviews and tracks implementation of workplan.
▪ **HHS Administrator**	▪ Tracks implementation of workplan; directly supervises CQI staff.
▪ **Quality Improvement Consultant**	▪ Provides contractual oversight of staff; assists in implementation of workplan.
▪ **Quality Improvement Coordinator**	▪ Coordinates daily operations of CQI; assists in overall QI development; generates analyses and reports; oversees day-to-day development of program; attends planning meetings; reviews existing literature related to quality development and improvement; coordinates capacity building activities.
▪ **HHS ARIES Team**	▪ Monitors HHS ARIES Database; monitors client and service level data compliance standards; assists in designing CQI plan; advises on performance indicators; creates reports from raw data; analyzes and reports on CQI results; trains and updates provider users as needed.
▪ **San Mateo and Marin Co. QI Representatives**	▪ Oversees all Quality Management activities in their counties and respective providers.

Number of Staff FTEs Assigned to Quality Management: The SF EMA has a total of **5.7 FTE** devoted to QM activities. Designated Quality Management staff distributed by specific EMA counties includes: San Francisco - **4.15** FTE; San Mateo - **.80** FTE; and Marin - **.75** FTE.

Entities Under Contract for QM Program Activities: Consultant services are used to support a wide range of critical QM-related activities. As noted above, key coordination and oversight of the local QM process is carried out by the Quality Management Program Consultant who has responsibility for key planning and implementation activities related to the EMA's quality management program. Additional consultants conduct a variety of activities such as

developing training curricula for new standards of care; leading and presenting trainings in standards of care and other relevant topics; and developing measurable outcomes for HHS CARE-funded services. Data management consultants support compliance with ARIES and to offer individualized TA assistance to Ryan White contract providers.

CQM Resources and Training Provided to Grantee Staff, QM Team, and Sub Grantees: All data administration staff members across the San Francisco EMA have attended HRSA RSR trainings and regularly participate in California Office of AIDS ARIES webinars with regard to data entry improvement for key indicators that include PCP prophylaxis, income, number in household, insurance, and current living status. The QM Team has also received training in the utilization the National Quality Center's (NQC) modules and tools with a special focus on organizational assessment; the utilization of Plan, Do, Study, Act (PDSA) cycles; and the provision of technical assistance in supporting HIV service agencies in creating and implementing high-caliber quality management plans.

To prioritize quality management projects and improvement areas within the regional Ryan White system, an annual **training needs assessment survey** is sent out to Part A-funded agencies for input. Thus far during calendar year 2013, the following **6** topical trainings have taken place based on input received from providers: 1) Transgender Best Practices (2 sessions held) ; 2) De-escalation; 3) Creating a Sustainable Business Model; 4) Leveraging Resources; 5) Update on HIV Treatment and Care; and 6) HIV Quality Management. Standards of care training sessions have also been held on the topics of medical case management, mental health, and substance abuse services. Overall topic-specific trainings consistently receive positive participant feedback. The San Francisco HHS ARIES team has also provided training in 2013 at individual agencies on the topics of RSR preparedness; ensuring RSR completeness; and utilizing "fix-it" reports to address shortcomings in data quality and scheduling. This training is in addition to ongoing monthly ARIES training for all new users throughout the EMA's Part A service system.

1.A.2) CQM Program Processes and Activities

Specific Performance Measures Being Monitored: The intent of Quality Indicators is to identify markers for tracking **measurable health outcomes** as a result of services rendered by providers. At the present time, tracking of indicators centers on the EMA's **HIV Centers of Excellence** in order to monitor the effectiveness of the system's integrated, comprehensive approach to care for severe needs populations. Among the specific indicators monitored through this system are: a) indicators related to **primary medical care**, through which providers must achieve at least an **85% compliance rate** in regard to standards and procedures such as ARV Therapy Management and PCP and MAC prophylaxis; b) attainment of a **75%** goal in screening clients for barriers to **treatment adherence**; c) a **case management** indicator with a minimum **85% target** for clients remaining engaged in primary medical care while receiving services; d) an indicator related to **outpatient mental health** in which at least **90%** of clients must be screened for an active psychiatric illness; and e) an **outpatient substance use** indicator ensuring that at least **90%** of clients are screened for active substance abuse and dependency problems. All indicators are continually used to improve the quality of Ryan White services. These performance measures are tracked at the client level in both case management and medical plans.

In order to track indicators, HIV Health Services establishes **benchmarks** with each agency at the beginning of each contract period and provides training and technical assistance to ensure that agencies understand and are able to meet ARIES data reporting requirements. HIV Health Services aggregates agency data to track progress toward stated indicators and discusses variations with agencies when they are identified. HHS also works with agencies to

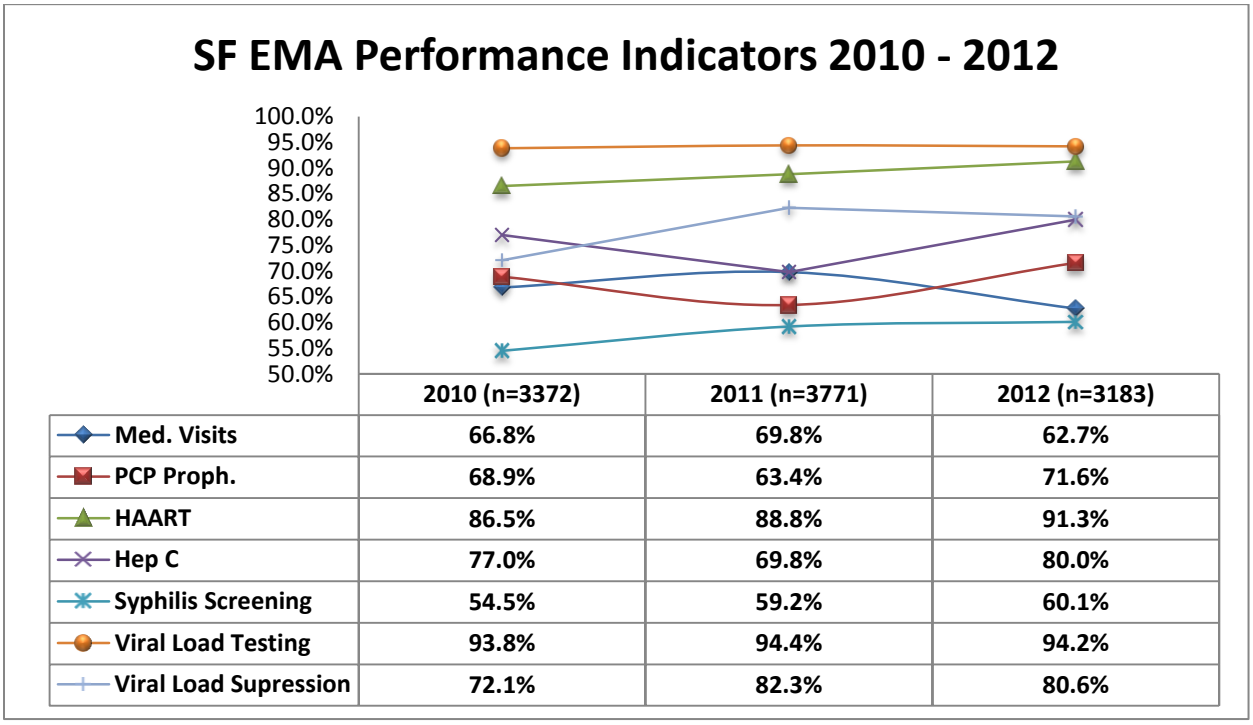
collaboratively develop remedial responses to ensure adherence to quality standards.

QM Data Collected to Date and Results: Currently, performance indicators are collected for **all** recommended HAB HIV/AIDS Performance Measures for Adults and Adolescents. An annual analysis report of overall performance is created by the Data Systems Administrator. Data runs were conducted on 9/17/2013 for Ryan White contract year 2012-2013. The total unduplicated client count (UDC) for all HHS primary care clients was **3,359**. Inclusion criteria was based upon a client receiving at least **two** primary care visits during the measurement year (n=**3,183**), which represented **94.8%** of all EMA primary care clients in 2011. Key EMA-wide data findings from this period included the following:

- **Medical Visits Analysis**: While there is no established national consensus on performance level thresholds for this indicator, the EMA's internal **85%** local performance level threshold goal of at least **two** medical visits per year was not met. However, the EMA's overall performance level of **62.7%** achieves **73.1%** of the local threshold goal. There are several reasons for the EMA not meeting the 85% performance standard in 2012. The most significant cause involves the fact that an increasing number of clients are considered by their HIV care provider to be medically "stable". This is resulting in many physicians requiring **less frequent client visits** than the minimum two per year currently prescribed by local standards. This trend may require the EMA to re-examine its standards for medical visits. Additionally, during this 2012 review period, the implementation of the Low Income Health Program (LIHP) has resulted in both San Mateo and San Francisco transitioning a number of Ryan White clients into their respective LIHPs, thus affecting this performance outcome. LIHP transitioned clients who may have been included in the denominator of the potential criteria pool and no longer appear to have had sufficient services or data to be also included in the numerator by criteria formulas.
- **HAART Analysis**: The **80%** national and **85%** local threshold goals were met or exceeded in all groups. The San Francisco EMA-wide performance level of **91.3%** achieves **107.7%** of local and **114.1%** of national threshold goals.
- **Viral Load Suppression Analysis**: The 90% local and national performance level threshold goal was met and exceeded by Marin and San Mateo. The SF EMA wide performance level of 80.6% achieves 89.6% of the local and national threshold goal.
- **Hepatitis C Screening Analysis**: The **95%** national threshold goal and the **85%** local performance threshold goals were not met. The San Francisco EMA wide performance level of **80%** achieves **94.1%** of the local and **84.2%** of the national threshold goal. Reasons for failing to meet the national and local threshold goal includes the fact that many local electronic medical record systems do not yet have a data elements for hepatitis C screening and that this particular data element was entered in ARIES as "unknown" as opposed to "not medically indicated" so clients could be excluded from calculation. HHS is working with its Part A subcontractors to ensure that hepatitis C is included as a reportable field in all electronic health record systems while addressing misreporting issues.
- **PCP Prophylaxis Analysis**: Neither the **85%** local or **95%** national thresholds were met, although the San Francisco EMA wide performance level of **71.6%** achieves **84.3%** of the local and **75.4%** of the national threshold goal. As with hepatitis C screening, a key reason for the EMA not meeting national and local threshold goals includes the fact that many providers enter this data element in ARIES as "unknown" as opposed to "not medically indicated" so that clients can be excluded from calculations.

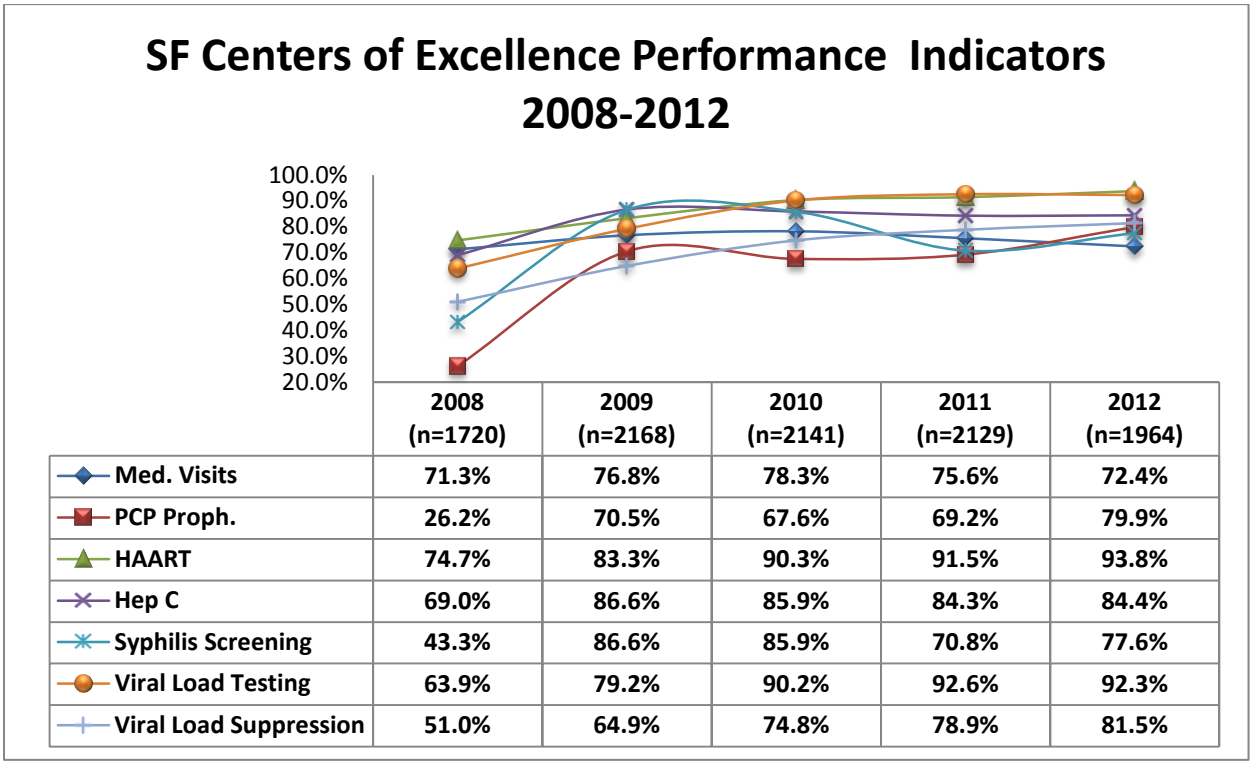
- **Syphilis Screening Analysis**: The **90%** national and the **85%** local performance level threshold goal was met and surpassed by Marin County while San Francisco and San Mateo Counties did not meet the local or national thresholds. The SF EMA wide performance level of **60.1%** achieves **70.7 %** of the local and **66.8 %** of the national threshold goal. Reasons for those failing to meet the national and local threshold goal(s) could be: a) there is no screening data element in the client electronic medical record, which means that information may be buried in progress notes or simply not noted as a rendered service; b) the data element was entered in ARIES as "unknown" as opposed to "not medically indicated" so client could be excluded from calculation; and c) ARIES data entry is not complete for all clients.

The **EMA Systemwide Quality Indicators 2010-2012 Trends Chart** on the following page illustrates the HAB HIV/AIDS Performance Measures results for the EMA's primary care service providers over the last three years. **San Francisco's Centers of Excellence Summary Chart** of the 2008-2012 calendar years. All indicators are based on clients receiving at least **one** primary care visit during the measurement year.



	2010 (n=3372)	2011 (n=3771)	2012 (n=3183)
Med. Visits	66.8%	69.8%	62.7%
PCP Proph.	68.9%	63.4%	71.6%
HAART	86.5%	88.8%	91.3%
Hep C	77.0%	69.8%	80.0%
Syphilis Screening	54.5%	59.2%	60.1%
Viral Load Testing	93.8%	94.4%	94.2%
Viral Load Supression	72.1%	82.3%	80.6%

Analysis of Chart Above: With the completion of the 2009-10 EMA data base conversion onto ARIES a good baseline was established. A steady state performance is shown over the three year period for all indicators. A slight progression for HAART, Viral Load Testing, Viral Load Suppression and Syphilis screening indicators is shown. Hep C screening and PCP Prophylaxis took a slight dip in 2011 but appear to be progressing back to or gaining on previous performance levels. The indicator for Medical Visits seems to be in a decline since its peak in 2011, most likely due to the implementation of LIHP in San Mateo and San Francisco which transitioned a number of clients out of this reporting system.



	2008 (n=1720)	2009 (n=2168)	2010 (n=2141)	2011 (n=2129)	2012 (n=1964)
Med. Visits	71.3%	76.8%	78.3%	75.6%	72.4%
PCP Proph.	26.2%	70.5%	67.6%	69.2%	79.9%
HAART	74.7%	83.3%	90.3%	91.5%	93.8%
Hep C	69.0%	86.6%	85.9%	84.3%	84.4%
Syphilis Screening	43.3%	86.6%	85.9%	70.8%	77.6%
Viral Load Testing	63.9%	79.2%	90.2%	92.6%	92.3%
Viral Load Suppression	51.0%	64.9%	74.8%	78.9%	81.5%

Analysis of Chart Above: A steady performance progression for HAART and Viral Load Testing and Viral Load Suppression indicators is shown over the entire reporting period. Hep C screening and PCP Prophylaxis have remained fairly constant over the last four years. The indicator for Syphilis Screening seems to be making progress over the last two years since its decline in 2010. The indicator for Medical Visits seems to be in a decline since its peak in 2010, this is most likely due to the implementation of LIHP in San Francisco which transitioned a number of clients out of this reporting system.

How Data Is Reviewed and Validated and How Data is Shared with the Planning Council: Current indicators are reviewed by the CQI Committee to ensure specificity, relativity, accuracy, and traceability to the needs of clients. Data analysis is initially prepared by HHS staff with input from the other EMA county staff for verification of findings. Data reviews also take place during HHS provider meetings and in the context of SF EMA Committee meetings. Meanwhile, the Director of HIV Health Services provides ongoing updates and information on quality management activities to the San Francisco HIV Health Services Planning Council. The Quality Management Program Consultant and the HIV Health Services Data Systems Coordinator also provide regular formal progress reports to the Council on the status of the quality management program and the client-level data system. HHS prepares an annual EMA CQI presentation which consists of a description of all indicators including national and local threshold performance goals; a graphic depiction for each which illustrates aggregate results by county; an analysis of data findings; a statement of whether or not performance goals were met; and reasons if not met and next steps for quality improvement. In addition, a five-year trend chart of the QM indicators is shared on at least an annual basis with the Council.

Process to Determine Priorities for QM Projects and QM Monitoring: As noted above, HIV Health Services distributes an annual **training needs assessment survey** to Part A-funded agencies to prioritize quality management projects and improvement areas within the regional

Ryan White system. However, continual agency monitoring also provides an opportunity for HHS to identify areas for quality management improvement among providers. Through established processes, HHS staff alert the Quality Management Program Consultant whenever a problem or issue is identified and an agency assessment is quickly initiated. Based on this assessment, a **technical assistance plan** is developed and implemented in collaboration with the agency to provide skills-building and support for improving client care.

Regular assessments of subcontractor agencies include a review of the previous year's RSR data completeness report; a review of the agency data flow processes; identification of key staff who collect data; where collected data is stored; how data is retrieved for ARIES input; and who reviews ARIES data quality. Data elements and/or indicators that fall short of compliance standard are specifically examined for all QI projects. HHS encourages the utilization of Plan Do Study Act (PDSA) cycle models for quality improvement projects at individual agencies.

Specific Quality Improvement Projects Currently Being Implemented in the EMA: The basic goal of the QM system is threefold: 1) To ensure continuous, accurate electronic data collection and analysis of Ryan White-funded services in the SF EMA through the region-wide ARIES database for Part A-funded services; 2) To reliably track progress toward established markers and milestones that are indicative of the quality of service provided; and 3) To continually improve and enhance client service practices and outcomes through accurate and timely service data. As previously noted, each service provider conducts their own CQI projects and reports finding in the monitoring process as required. At the same time, HHS also frequently establishes overarching QI projects across all agencies which generally relate to improvements in data recording and transfer. In 2012, the principal EMA-wide QI focus was on **increasing data integrity and comprehensiveness** for 2013 RSR submission. As a result of ARIES Data Flow discussions with key providers, it was further agreed to focus on the completion of data elements involved with insurance and income status. Assurance that all health outcome elements with particular focus on viral load testing and monitoring are entered in ARIES was also affirmed.

Process to Implement, Monitor and Evaluate the Quality Management Plan: The QM Plan plays an ongoing, integral role in client service delivery within the San Francisco EMA and has been implemented in a variety of ways, including: a) inclusion of quality management requirements and health outcome indicators in provider contracts and RFPs; b) distribution of an annual training calendar to service providers; c) promulgation of Standards of Care and Best Practices documents on the HIV Health Services website; d) inclusion of data collection expectations in provider contracts and RFPs; and e) annual client satisfaction surveys.

Several critical aspects of care are monitored throughout each contract year, including primary care health outcomes, provider education, client satisfaction, continuity of care and case management services, and client medical records. The San Francisco EMA utilizes the HAB performance measures tracked through ARIES. Reports on the various performance measures are generated on a routine basis and delineate both the aggregate data for the EMA and agency-specific data for the Centers of Excellence. This data allows the EMA to assess tracking of health outcomes and evaluate system-wide or agency-specific issues in both client care and data collection. System-wide issues are discussed with the Director of HIV Health Services, the Quality Management Consultant, data collection specialists at HIV Health Services, and providers at the monthly CoE meetings. These meetings serve as a forum for discussing care-related issues and performance measures and are attended by the QM consulting staff.

For agency-specific issues, the EMA has established a **written protocol** for accessing Technical Assistance through the Quality Management Program. Agency-specific issues are

discussed with the Director of HIV Health Services, the DPH Business Office Program Manager, and the Quality Management Consultant. Typically, a **written technical assistance plan** is developed - such as a chart review or staff training - and implemented with one of the Quality Management TA consultants and the agency. Progress is updated with the Business Office, Contract Development, and Technical Assistance Manager and a report, including any further recommendations, is submitted the HIV Health Services Administrator and Director and the agency at the completion of the technical assistance period.

Annual agency site visit monitoring provides another opportunity for monitoring and evaluating the Quality Management Plan. Client satisfaction and staff training for Standards of Care and Best Practices are monitored by HIV Health Services and any issues are identified for technical assistance. Provider meetings and training evaluations from provider trainings and workshops can also serve as useful mechanisms for evaluating the Quality Management Plan.

Participation of Clients in CQM Implementation and Evaluation: HIV-infected consumers play a critical role at all levels of the SF EMA CQM planning and implementation process. The San Francisco HIV Health Services Planning Council and its quality committee - a majority of whom are persons living with HIV - review, revise, and participate in producing CQM standards, systems, and support. At the agency level, subcontractors rely on ongoing client satisfaction surveys to assess the qualitative impact and effectiveness of agency services, while working directly with consumers to collect required data and ease the burden of data collection and reporting on clients. The results of consumer needs assessment processes also directly influence the design and implementation of CQM projects, as do findings related to changing client utilization of Ryan White Part A services.

1.B) Data for Program Reporting

Description of MIS System for Data Operations: ARIES is a custom, web-based, centralized HIV/AIDS client data management system that provides a single point of entry for clients, allows for coordination of client services among providers, meets HRSA and State care and treatment reporting requirements, and provides comprehensive data for program monitoring and scientific evaluations. ARIES enhances services for clients with HIV by helping providers automate, plan, manage, and report client and service level data. ARIES incorporates **four** integrated applications that work in conjunction with one another, as follows:

- The **ARIES Client Application** is the main application through which staff enters client data and search, edit, and generate reports from records.
- The **ARIES Report Export** application allows users to define custom reports. Users can also export ARIES data in a variety of formats including XML for inclusion in other applications.
- The **ARIES Import Application** allows users to bring data into ARIES from other sources. ARIES Import accepts XML files, checks them for validity, and then inserts or updates the database with the newly imported data.
- The **ARIES Administration Application** allows users to monitor and control ARIES activity as well as customize ARIES edit screens.

ARIES employs multiple layers of security to protect access to data. Each user has a unique login and password to access ARIES. In addition, each computer must have a separate digital security certificate installed for **every** user who accesses the system. Not all users have access to all ARIES functions. HHS ARIES administrators have fine-grained control over who has access to which parts of the system. Lastly, the ARIES web servers and databases are protected by firewalls to prevent unauthorized access.

Description of Current Client-Level Data Capabilities: As of July, 2010 all of the EMA Ryan White funded service providers were converted to use of the AIDS Regional Information and Evaluation System (ARIES) system, with San Mateo County (5 agencies) completed first in early 2009; San Francisco County (60 agencies) completed in April 2010; and Marin County (4 agencies) completed in July, 2010. Providers continually enter client-level service and demographic data, including quality related measures, which are automatically uploaded into the common system. All service providers are encouraged to run **quarterly reports** which indicate any missing data for RSR reporting purposes. Data reporting requirements are part of the standing agenda of the monthly Centers of Excellence meetings which all primary care service providers attend. Additionally, HHS conducts a regular provider meeting specifically focused on data compliance and completeness in preparation of RSR submission. HHS as the grantee enters all RSR uploads into the **HRSA HAB Electronic Handbook (EHB**). Meanwhile, ARIES is linked to the State Office of AIDS database which allows for statewide tracking of service utilization and outcome data encompassing all counties except for Los Angeles County.

How QM Data Have Been Used to Change and Improve Service Delivery in the EMA: Based in part on quality management data received, the San Francisco Planning Council has reaffirmed the continuing focus of the EMA's Centers of Excellence on **persons with severe need** and **special populations**. Recent refinements made by the Planning Council based on the use of data include: a) expanding the EMA's definition of special populations to include PLWHA **age 60 and older**; b) integrating existing Early Intervention Programs into the CoE model; and c) for the purposes of the CoE, specifying the inclusion of individuals living in neighborhoods in which health disparities and HIV are co-prevalent including the Tenderloin, the Mission, South of Market, and the Southeast Corridor of San Francisco.

ORGANIZATIONAL INFORMATION

1) Grantee Administration

1.A) Program Organization

1.A.1) Administration of Local Part A Funds

The grantee agency for Ryan White Part A funds in the San Francisco EMA is the **City and County of San Francisco Department of Public Health.** Ultimate authority for the administration and expenditure of Part A funds lies with the city's **Mayor, Edwin M. Lee**, 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 **Barbara Garcia, MPA,** who serves as **Director of Public Health** for the City and County of San Francisco (see Organizational Chart in **Attachment 10**). The administrative unit overseeing the Part A grant is **HIV Health Services (HHS)**, an organizational unit of the San Francisco AIDS Office, overseen by **Marcellina Ogbu, PhD,** who serves as **Director of Community Programs** and **Deputy Director for Public Health** for the City and County of San Francisco**.** The **Director of HIV Health Services** is **Bill Blum, LCSW,** who has served in this capacity for 4½ years. A staff of **9 DPH** employees - each funded with different levels of Part A support - is responsible for directing, coordinating, and monitoring the distribution and expenditure of Part A funds throughout the EMA, working a combined total of **6.10 FTE**. Additionally, a combined total of **1.25 FTE** of staff time is dedicated to Business and Finance Services; **0.2 FTE** to Personnel Services; **1.0 FTE** to Accounting Services; and 1.65 FTE to the Contracts Administration section (see attached Budget Justification for description of individual staff roles and

percentages). 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 Part A funds. At the time of this writing, the Council's work is coordinated by **three Co-Chairs**, **Lee Jewell, Channing Wayne,** and **Mary-Lawrence Hicks, NP**. Co-Chairs are elected annually for staggered terms 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. Four additional standing committees support the work of the Council: **Consumer and Community Affairs; Government and Provider Affairs; Steering Committee; and Membership.** Administrative support for the San Francisco HIV Health Services Planning Council is provided through a subcontract to **Shanti Project**, a non-profit service organization**.** The **Director** of Planning Council Support, **Mark Molnar, is** a former long-term member of the Planning Council and previously served as Co-Chair.

The two additional counties that make up the San Francisco EMA have responsibility for administering and distributing Part A funds through their counties' respective health departments. In San Mateo County, Part A funds are coordinated through the **San Mateo County Health System's Director, Jean Fraser**. Responsibility for Part A fund administration lies with **Matt Geltmaker,** who serves as **Director of the San Mateo County STD/HIV Program** and is responsible for oversight of all Ryan White Part A, Part B, MAI, CDC, HIV prevention, and HOPWA funds as well as subcontractor oversight. In Marin County, Part A and B funds are administered through **County of Marin Health and Human Services**, whose Director is **Larry Meredith, Ph.D.** He shares responsibility for Part A funds with **Margeret Kisliuk, Associate Director of Public Health Services.** The **Marin County HIV/AIDS Program** has direct responsibility for Part A fund management and coordination. Direct oversight of Marin Part A funds is provided by **Cicily Emerson, 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.

1.A.2) Distinguishing of Funding Streams

The San Francisco EMA has always worked to ensure that Ryan White Part A and B funds are used as the funding source of last resort and that Part A expenses are distinguished from other Ryan White sources, including differentiating between MAI and Part A funding. In the case of the San Francisco EMA, our task is simplified by the fact that local Minority AIDS Initiative funds specifically go to support the work of **Mission Center of Excellence**, a multidisciplinary client service site operated by Mission Neighborhood Health Center. This means that all clients served at the CoE are MAI versus Part A-funded clients, and eliminates the need for other agencies to track Part A and MAI clients separately.

1.B) Grantee Accountability

1B.1) Grantee Accountability Narrative

a) **<u>Implementation of National Monitoring Standards:</u>** San Francisco HIV Health Services has worked closely with the DPH Contract Compliance office to coordinate implementation of the National Monitoring Standards, which it has reviewed thoroughly and which it has summarized in presentations to the San Francisco HIV Health Services Planning Council. In 2011, **all** Ryan White providers of client services received a mid-year site visit to

document that Ryan White client eligibility is confirmed by programs upon intake and every six months thereafter and that Ryan White funds are the payer of last resort. Contract Compliance Program Managers have developed and utilized check-lists to determine that systems were in place for these and other procedures necessary for program compliance and attaining quality client services. Additionally, Part A-funded programs were made aware of program and fiscal monitoring policies highlighted in the National Monitoring Standards, including the list of non-allowable costs and the 10% aggregate administrative cost cap. At the end of 2011 and 2012, as stipulated in the Standards, **all** programs were visited by the Contract Compliance and HIV Health Services Units of the Community Programs Section of SF DPH for an on-site program and fiscal monitoring check to document program compliance. HIV Health Services has initiated and continues to have on-going monthly conversations with its HRSA Project Officer discussing short and long-term plans and efforts to maintain compliance with National Monitoring Standards.

b) Process to Track Formula, Supplemental, MAI, and Carry Over Funds: As noted above, the San Francisco Department of Public Health (DPH) is the local government agency responsible for the administration of Part A funds. SF DPH oversees all public health services for the City and County of San Francisco as well as contracts with community providers using processes required by local ordinances. MAI, carry forward and other specific types of Ryan White funds and local General funds are placed in separate budget appendices, and have specific and separate invoices. Formula and Supplemental funds are also specifically allocated and tracked to ensure appropriate accountability. Service solicitations delineate fiscal monitoring and reporting expectations for contracted services and all proposals must adequately describe each agency's ability to perform accountability-related activities. This includes the production of specific, measurable goals and objectives; documentation of the agency's prior experience in providing services to target populations; and language capacity. Oversight also includes verification that contractors fully monitor third party reimbursements and document that clients have been screened for and enrolled in all eligible benefits and/or insurance programs so that Ryan White Program funds are used as the funding source of last resort.

In regard to fiscal monitoring, the staff of the City and County of San Francisco Controller's Office monitors federal funds awarded to nonprofit organizations. For nonprofit organizations receiving $500,000 or more in federal funds, the Controller's Office reviews audited financial statements and single audit reports for compliance with the Single Audit Act and OMB Circular A-133. In Fiscal Year (FY) 2011, the Controller reviewed single audit reports for a total of **27** DPH organizations including **13** Part A-funded organizations. The Controller found that all of these organizations had appropriate and timely corrective action plans in place.

As of August 2010, San Francisco EMA programmatic monitoring, contract development, oversight, compliance and monitoring functions are overseen by the Department of Public Health's new Community Programs Business Office, created in an effort to consolidate services and maximize efficiencies. The new centralized Business Office is staffed by **18** program managers from Community Behavioral Health Services, Housing and Urban Health, HIV Health Services, and HIV Prevention Services and consists of two sections: **1)** the Contracts Compliance Unit (CCU) and **2)** the Contract Development and Technical Assistance Unit (CDTA). The Contract Compliance Unit provides annual program review; conducts controller's fiscal and compliance review for DPH contracts; performs fiscal audits; oversees provider certification and licensing (PPN and Civil Service); performs site certification reviews; and, if indicated, oversees corrective action plan development and oversight. The Unit

also ensures that contracted Part A programs: a) are effectively managed; b) meet their contract goals; c) serve their target populations in professional and culturally competent ways, including adhering to published standards of care; and d) maximize external resources to ensure that Ryan White dollars are always used as the funding source of last resort. Additionally, all EMA member counties employ strategies to clarify provider responsibilities, track contractor performance, monitor service quality, and ensure maximum reimbursements.

c) Ensuring Timely Monitoring and Redistribution of Unexpended Funds: All contractor invoices are reviewed on a **monthly** basis to ensure that deliverables do not fall below **90%** of contractual objectives. If a program is having difficulty reaching its 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 in a written action plan the actions that will bring the deliverables up to target by the end of the next quarter. Common resolutions of invoicing problems include reducing contract funding levels in future years; withholding payment of 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.

HIV Health Services maintains a system for tracking all funding **by funding source** including formula and supplemental funds. Additional tracking systems exist within the AIDS Office Contracts Unit and the DPH Fiscal Unit. A **bi-weekly budget meeting** attended by staff from all four units ensures accurate tracking across programs. **For FY 2012, all Part A funds were put into contracts and there were therefore no unobligated dollars.** In FY 2012, HIV Health Services also conducted both a **service category** and a **program level analysis** based on past and current fiscal performance to assign and track formula and supplemental funds. Formula dollars were prioritized to fund core services and supplemental dollars were targeted to fund support services.

The EMA strives to ensure that the least possible amount of Part A funds are left unspent and held for carry-over at the conclusion of each fiscal year. Unexpended funds are identified by multiple agency queries during the last quarter of the fiscal year. As part of this process, a program analysis was conducted on invoicing patterns following the first half of the FY 2012 Ryan White contract year. Those agencies identified as under-spending through this analysis were contacted to ensure either that all monies would be spent or that anticipated left over dollars could be reallocated. In June of each year, HHS reports out on the unexpended funds dollar amount to the San Francisco EMA HIV Health Services Planning Council, which then reallocates them to be expended during the current fiscal year. The requested reallocation of Carry-Forward funds is explained in detail and sent to HRSA for approval annually. For FY 2012, only **1.5%** of RWPA allocated funds were left unexpended, and most of this was due to staff vacancies experienced toward the end of the contract term.

d) Fiscal and Program Monitoring Process: The Controller's Office oversees a citywide fiscal and compliance monitoring program which includes over **200** organizations (including agencies receiving less than $500,000 in federal funds) contracting with multiple County departments. Organizations to be reviewed are selected through a risk assessment process and site visits are conducted a minimum of once every three years. Monitoring visits are conducted by a team led by the agency's assigned program officer. The team utilizes previous agency data and reports and conducts the visit following a pre-established site visit protocol. Following each fiscal and compliance monitoring site visit, staff from the city department leading the team issues a monitoring report to each organization specifying and explaining findings and setting a

deadline for a written response. Organizations determined to need an improvement in fiscal practices are provided with technical assistance and ongoing oversight.

e) Frequency of Fiscal and Programmatic Monitoring Site Visits: A total of **21** separate community-based service contractors are funded through Ryan White Part A funding in the San Francisco EMA. As per National Monitoring Standards requirements, all Ryan White funded programs receive a programmatic monitoring **every year**. Thus far in FY 2012, a total of 21 SF DPH funded organizations as well as **10** separate DPH funded programs and **6** subcontractors funded through the EMA's two other counties have already received a site visit and document review as part of the DPH Contract Compliance Section's Fiscal and Comprehensive monitoring process. This represents **100%** of Ryan White Part A funded agencies. Also in FY 2012, a total **10** out of **21** (**48%**) Part A-funded community-based organizations will receive a City-Wide Fiscal and Compliance site visit (coordinated across multiple SF city departments, which include review for Ryan White monitoring standards) while the other **11** will receive self assessments as part of this city-wide monitoring process. During FY 2011, all problems identified through site visits were relatively minor and fully correctable; examples include incomplete documentation contained in agency personnel files and lack of full participation by contract agency staff in collaborative case conferences.

f) Process and Timeline for Corrective Action: Whenever a specific programmatic concern is identified at a Part A-funded agency, information is **immediately** sought from staff of the contracted agency. 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 accompanied by 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. Grantee staff follows up on areas of concern after reports have been received. TA is provided for contracting agencies in areas such as staff training and orientation, adoption and replication of best practices, and/or collaboration. Agencies with ongoing problems are referred to the Fiscal Compliance Unit's Contract Oversight Committee which works to develop a corrective action plan for the agency to maintain ongoing funding and good standing.

g) Total Contractors and Number Receiving Fiscal or Monitoring Visits in FY 2012: As noted above, a total of **21** separate service contractors are funded through Ryan White Part A funding in the San Francisco EMA. All 21 of these agencies have already received an FY 2012 site visit and document review as part of the Citywide Fiscal and Comprehensive monitoring process, representing **100%** of Ryan White Part A funded agencies. During FY 2012, **10** of a total of **21** (**48%**) Part A-funded community-based organizations will receive a City-Wide Fiscal and Compliance site visit (which include review for Ryan White monitoring standards). In addition to the SF Controller's office's fiscal review, SF DPH Contracts and Compliance Unit will conduct on-site fiscal reviews and site visits of the remaining **11** contract agencies **(52%), conducting self assessments**, which will take place between January and March of 2012**.**

h) FY 2012 Improper Charges / Findings and Summary of Action Plans: In this current climate of challenging economic times, SF DPH actively engages with contractors, who are seen as community partners providing vital services to clients. Over the last three years, several SF non-profit service providers have either closed their doors or been involved in mergers due to rising costs, diminishing funding, and economic shortfalls. There are currently **no** HHS Ryan

White funded programs that are involved in what SF DPH calls a **Corrective Action Plan (CAP).** When programs are identified for a Corrective Action Plan, staff from DPH and the Controller's office continue to meet regularly with this program and its auditors to resolve its audit issue and help the program to become stronger and more fiscally viable, and to improve program performance.

i) Number and Type of Contractor TA Visits: In FY 2012 to date, as an integral element of the HHS Quality Management Program, Part A dollars have funded a **Comprehensive Technical Assistance program** that has provided support to an estimated **19** agencies who collectively received a total of approximately **564** total hours of technical assistance. A total of **220** agency staff participated in some form of TA during the 2011 Fiscal Year. Technical assistance services are in part focused on ensuring that contracted agencies continue to maximize and coordinate all potential non-Ryan White reimbursement streams in support of HIV patient care, including sources such as Medicare, Medicaid (Medi-Cal), Veteran's health care benefits, private health insurance, and other programs, and that agencies carefully monitor all third party reimbursements. Additional areas of technical assistance provided include: 1) support for establishing collaborative partnerships, including issues and expectations among Centers of Excellence partners and integrating client service delivery systems; 2) improving client recordkeeping and documentation; 3) utilizing chart reviews to assess and assist in maintaining client records and tracking client care outcomes, including collaborative care planning; 4) providing clinical assistance in establishing multidisciplinary client case conferencing between Centers of Excellence partners; and 5) providing medical case management training.

j) Number and Percentage of Contractors Compliant with OMB Circular A-133 Audit Requirements: Twenty-one of 21 HHS Contractors (**100%**), required to provide an OMB Circular A-133 Audit report for the last fiscal year have done so.

k) Responses to Problems in Relation to Audit Requirements: Last year, the Director of the DPH Business Office of Contract Compliance (BOCC) worked with DPH fiscal staff and the Controller's Office of the City & County of San Francisco to address the above audit matter via technical assistance. Experienced DPH and Controller's Office staff were involved in working with the relevant agency to resolve these issues. Last year, these services were put out to bid through an RFP process and the agency with the audit issues and the Corrective Action Plan in FY 2011 was not awarded any funding. Clients and funding for this program were successfully redirected to another community provider.

l) Payment of Contractor / Subcontractor Vouchers: HHS contractors submit monthly invoices to the DPH AIDS Fiscal Invoice Section for review and submission for reimbursement. The AIDS Fiscal Invoice staff employs **two** invoice analysts who review invoices for accuracy and performance and - upon approval - forward to the Accounts Payable Contracts and Reconciliation section for payment. The invoice analyst reviews invoice line items to control for over-invoicing and also ensures that submitted invoices match final or modified contract budget details. An additional function of the invoice analysts is to check the level of contract deliverables (both contract units and unduplicated client targets) **quarterly** and to calculate if the program performance is within the 90% range required at these "milestone" reviews. Programs not performing within 90% of "milestone" marks have their invoices held without payment and their invoices are sent to the CDTA Program Manager and the HHS Administrator for review and consultation. The program is then contacted and the source of the underperformance is discussed. If deemed necessary, the program is requested to submit a written explanation and a course of action to correct the issue and work toward getting caught up on contract deliverables.

Once approved by the HHS Administrator or Director, the invoice analysts then move forward with processing for payment. Once the AIDS Office Fiscal Analysts review and process for payment, the Accounts Payable – Contracts and Reconciliation section performs their final review and forwards to the Controller's Office for payment. Payments are either sent by check via U.S. Mail or deposited electronically into the contractors' bank account by SF's Auto Clearinghouse Payment Processing for those contractors who establish this mechanism with the City. Payments are processed once weekly.

1.B.2) Fiscal Staff Accountability

Roles and Responsibilities of Fiscal Staff: Responsibility for fiscal monitoring and oversight of the Ryan White Part A grant lies with a **six-member team** at the San Francisco Department of Public Health Grants and Contracts Office. The team is supervised by the **Deputy Financial Officer, Anne Okubo,** who supervises and directs staff in the fiscal grants unit and payables section and supervises and directs all fiscal requirements for Federal, State and private grants for the Population Health and Prevention Section (PHP). This includes setting up grant accounting for new grants; reviewing and monitoring grant revenues, expenditures, and positions; analyzing revenues and expenditures; preparing fiscal reports; reconciling grant accounts; and closing out completed grants. The Accounting Manager is supported by **five Accountant IV,** each of whom supervises numerous accounting staff and oversees a range of program-related grants and contracts. The role of **Accountant IV for AIDS grants** is filled by **David Anabu.** The AIDS Accountant IV performs difficult accounting and analytical work in the Grants Unit and supervises and coordinates grants accounting and management of assigned grants from the AIDS Office. Complementing the work of the AIDS grants Accountant is the **Accountant IV, Payables-Contracts**, a role filled by **Margarette Alviar**. Among other tasks, Ms. Alviar supervises and directs staff in processing accounting transactions including encumbrance and payment documents and cost allocation activities within established and/or required timeframes. A third **Accountant IV, Payables Non-Contracts, Myrna Boongaling,** supervises and directs staff in processing accounting transactions including purchasing and payment documents, cost allocation activities within established and/or required timeframe, and ensuring compliance with appropriate rules and provisions. Additional fiscal staff includes **Elizabeth Woo,** Accountant IV for Maternal, Health, and Children grants and **Miguel Quinonez,** Accountant IV for Mental Health and Administrative Grants.

Process and Coordination of Fiscal Staff in Ensuring Adequate Reporting, Reconciliation, and Tracking of Program Expenditures: The Accountants IV and their staffs carefully review all Ryan White contractor and subcontractor programmatic budgets and reconcile expenditures in accordance with standard accounting practices. They also approve each grant fund encumbrance in accordance with availability of grant funding.

1.C) Third Party Reimbursement

a) Processes to Ensure that Contractors Monitor Third Party Reimbursements: The San Francisco Department of Health is committed to maximizing third party reimbursement across the EMA to ensure that Part A funds are always used as the funding source of last resort. This is not only to comply with Ryan White Act requirements, but because the fiscal crises local and state systems are facing compels the region to maximize its reimbursement streams. To this end, all three SF EMA counties have taken steps to ensure that all available reimbursement sources in the region are fully utilized, including: a) continually educating providers on the availability of third-party reimbursement streams; b) expanding the capacity of local organizations to bill for services, including assistance in obtaining licensure and

certification and 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. The EMA has also taken steps to verify that Part A contractors are fully maximizing reimbursement streams, and that rigorous protocols are followed to ensure that Part A funds are only used **after** all other funding sources have been exhausted. The generalized formula used by HIV/AIDS service providers to determine client benefits eligibility is to lead 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 to determine if third party insurance and Medicaid coverage are an option. Providers are then required to assist clients in obtaining 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 Ryan White funds will be used **only** for services that are not reimbursed through any other source of revenue and new contracting agencies receive training to familiarize them with other appropriate payment sources for specific services and programs.

b) Documenting Contractor Screening and Enrollment Services: Service providers are monitored to ensure compliance with Ryan White Program policy and guidelines pertinent to third-party reimbursement. Contracted service providers must provide 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. 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 Ryan White - such as Medicaid, Medicare, or private insurance – then that source **must** be billed before seeking reimbursement from Ryan White. **In these cases, payment received is considered as payment in full, and balance-billing to Ryan White is not permitted.** 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.

c) Monitoring Program Income and Rebates: HIV Health Services and the DPH Office of Contract Development and Technical Assistance require all agencies funded through White Programs to provide a complete budget summary of all program funding sources and incomes as well as program expenditures. All programs must demonstrate that their total program funding equals total program expenditures for each fiscal year in the budget.

1.D) Administrative Assessment

- **Monitoring Grantee Activities and Performance**
- **Corrective Actions or Suggested Improvements**
- **Strategies to Address Deficiencies**

The San Francisco HIV Health Services Planning Council conducts 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 Part A funds and contracts. In the Council's last comprehensive assessment 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 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 2012 application.

To improve ongoing communication and strengthen mutual planning , in 2005 the Grantee began to work with the Council to develop an **Action Plan** to address a mutually identified need for **more extensive and rapid information-sharing** between the two entities. This Action Plan - finalized in early 2006 - 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 **Memorandum of Understanding (MOU)** signed by the Council and HIV Health Services in February 2006 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; **3)** Both entities will use designated liaisons and channels of communication; **4)** Staff of both entities and Planning Council members will avoid inappropriate communication requests or channels; and **5)** 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 significantly advanced an already strong working relationship between the Grantee and the Planning Council, and serves as an ongoing framework setting clear expectations for what is expected of both entities in relation to information-sharing and open, respectful communication.

1.E) Maintenance of Effort - See **Attachment 11**

ENDNOTES

[1] The White House Office of National AIDS Policy, *National HIV/AIDS Strategy for the United States*, Washington, DC, July 2010, www.whitehouse.gov/onap
[2] US Census Bureau, *California QuickFacts*, Marin, San Francisco, & San Mateo Counties, September 30 2011
[3] State of California Department of Health Services, Office of AIDS, *California AIDS Surveillance Report: Cumulative Cases as of June 30, 2013*, Sacramento, CA, 2013.
[4] These and subsequent AIDS and HIV statistics in this section - summarized in the table in Attachment 3 - were derived from epidemiological data reports received from the Marin, San Francisco, and San Mateo County health departments in September 2012. The numbers of PLWHA in the three counties are based on an assumption of a 1-to-1 ratio of PLWA to PLWHA, based on consensus meetings held in the City of San Francisco in February 2012, including a review of over 50 different sources of data. 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).
[5] US Centers for Disease Control and Prevention, "Diagnosis of HIV Infection and AIDS in the United States and Dependent Areas, 2010, *HIV/AIDS Surveillance Report*, Vol. 22, February 28, 2012.
[6] San Francisco Department of Public Health, HIV Epidemiology Section, *HIV/AIDS Epidemiology Annual Report 2012*, San Francisco, CA, August 2013, www.sfdph.org/dph/files/reports/RptsHIVAIDS/AnnualReport2012.pdf
[7] US Centers for Disease Control and Prevention, Op. Cit.
[8] Per capita PLWA rates for Los Angeles County, New York City, and the City and County of San Francisco derived by comparing reported people living with AIDS as of December 31, 2012 in the case of Los Angeles and San Francisco and December 31, 2011 in the case of New York City with 2010 US Census Bureau populations for all three regions. LA County: 26,563 PLWA as of 12/31/12 / 2010 Census Population: 9,818,605; New York City: 67,082 PLWA as of 12/31/10 / 2010 Census Population: 8.175,133. Sources of AIDS data: County of Los Angeles Department of Health Services, Public Health, *HIV/AIDS Semi-Annual Surveillance Summary, Cases Reported as of December 31, 2012*, Los Angeles, CA, March 2013 and New York City Department of Health and Mental Hygiene, *HIV Epidemiology & Field Services Annual Surveillance Statistics 2011*, New York, NY, December 18, 2012.
[9] The New York City Department of Health and Mental Hygiene, Op. Cit.
[10] Because transgender identity is not tracked in San Mateo County HIV surveillance data, the actual EMA-wide total of transgender PLWHA is believed to be much higher than these estimates.
[11] Sources: San Francisco Examiner, *San Francisco's Homeless County Reveals Drop in Chronic Homelessness,* May 19, 2011; San Francisco Ten Year Planning Council, *The San Francisco Plan to Abolish Chronic Homelessness*, San Francisco, CA, September 2004; *Homeless in Marin*, Special Report, NorthBay Biz, San Rafael, CA, 2012, www.northbaybiz.com; and County of San Mateo Human Services Agency, Center on Homelessness, *2011 San Mateo County Homeless Census and Survey*, San Mateo, CA, May 4, 2011.
[12] Calculation based on total 22,928 PLWHA in the EMA as of December 31, 2010 with a conservative annual homelessness rate of 8% (n=1,834).
[13] Center for Juvenile and Criminal Justice, California Sentencing Institute, *2011 County Incarceration Profiles*, 2012, Sacramento, CA, www.cjcj.org
[14] California Criminal Justice Statistics Center, *Criminal Justice Profiles 2010,* Adult Felony and Misdemeanor Arrests, Sacramento, CA, 2011, http://oag.ca.gov/crime/cjsc-stats/2010
[15] Harder+Company Community Research, *HIV in San Francisco: Estimated Size of Populations at Risk, HIV Prevalence, and HIV Incidence for 2006*, Developed by Willi McFarland, San Francisco Department of Public Health, in partnership with the San Francisco HIV Prevention Planning Council, San Francisco, CA, April 2007.
[16] These and other Centers of Excellence statistics drawn from Zellers, R. & Whitney, E., *Final Public Report for Centers of Excellence Analysis*, Prepared for HIV Health Services, San Francisco Department of Health, San Francisco, CA, September 2008.
[17] Harder+Company Community Research, *Highlights from the 2008 San Francisco EMA HIV Health Services Needs Assessment,* prepared for the San Francisco HIV Health Services Planning Council, SF, CA, August 2008.
[18] State of CA Department of Health Services, STD Control Branch, "Primary and Secondary Syphilis, Cases and Rates, Counties & Selected City Health Jurisdictions, 2008-2012` Provisional Data," Sacramento, CA, 2013.
[19] Ibid.
[20] State of California Department of Health Services, STD Control Branch, "Gonorrhea, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2008-2012 Provisional Data," Sacramento, CA, 2013.
[21] Sources: Ibid. above for California data; for national data, CDC, Division of STD Prevention, *Sexually Transmitted Disease Surveillance 2009,* Atlanta, GA, November 2010

[22] Ibid. above for California data.
[23] State of California Department of Health Services, STD Control Branch, "Chlamydia, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2008-2012 Provisional Data," Sacramento, CA, 2013.
[24] Ibid.
[25] Chesson, H., Blandford, J., Gift, T., Tao, G., & Irwin, K., "The estimated direct medical cost of sexually transmitted diseases among American youth, 2000," *Perspectives in Sexual Reproductive Health*, Vol. 36, No. 1, January-February 2004.
[26] De Lissovoy, G., Zenilman, J., Nelson, K., Ahmed, F., & Celentano, D., "The cost of a preventable disease: Estimated US national medical expenditures for congenital syphilis, 1990," *Public Health Reports*, Vol. 110, No. 4, July – August 1995.
[27] Chesson, H., Pinkerton, S., Viogt, R., & Counts, G., "HIV infections and associated costs attributable to syphilis coinfection among African Americans," *American Journal of Public Health*, Vol. 93, No. 6, June 2003.
[28] Calculations based on the following: a) For total STI costs, calculation based on average of $1,000 per capita for syphilis and gonorrhea treatment (415 and 2,559 new cases, respectively, in 2011) and $500 average per capita for Chlamydia treatment (7,272 new cases in 2011) in the first year following diagnosis, including costs related to untreated cases; b) For STI treatment costs among PLWH, calculation based on est. 5% of persons living with HIV or AIDS becoming infected with non-HIV STI annually (n=1,158) at average treatment cost of $2,500 per capita, including costs of treating negative health consequences of STD among PLWHA.; and c) New HIV cases facilitated by STIs based on a total of 30 new HIV infections per year at an annual treatment cost of $15,000 x 10 years per person.
[29] St. Lawrene, J. & Brasfield, T., "HIV high risk behavior among homeless adults," *AIDS Education Prevention*, 7(1):22-31, 1995.
[30] National Low Income Housing Coalition, *Out of Reach 2012*, Washington, DC, 2012, http://nlihc.org/sites/default/files/oor/2012-OOR.pdf
[31] US Department of Housing and Urban Development, *The Final FY 2013 San Francisco County FMRs for All Bedroom Sizes*, Washington, DC, September 25, 2012, www.huduser.org/portal/datasets/fmr/fmrs/FY2013_code/2013summary.odn
[32] Applied Survey Research, *2013 San Francisco Point in Time Homeless Count and Survey*, February 19, 2013, www.sfgov3.org/modules/showdocument.aspx?documentid=4818
[33] San Mateo County Human Services Agency, Center on Homelessness, *2013 San Mateo County Homeless Census and Survey, Final Report*, San Mateo CA, May 2013 www.co.sanmateo.ca.us/Attachments/humanservices/Files/Homlessness/2013%20Census%20and%20Survey%20FINAL%20FINAL%205.10.2013.pdf
[34] NorthBay Biz, Op. Cit.
[35] San Francisco Ten Year Planning Council, *The San Francisco Plan to Abolish Chronic Homelessness*, San Francisco, CA, September 2004.
[36] Fagan, K., "S.F.'s homeless aging on the street," *San Francisco Chronicle*, Friday, August 4, 2006.
[37] Zolopa, A., et al., "HIV and tuberculosis infection in San Francisco's homeless adults: Prevalence and risk factors in a representative sample," *Journal of the American Medical Association*, 272(6), 1994.
[38] San Francisco Department of Public Health AIDS Office, "Data from the TREAT Study," in *2001 HIV Consensus Meeting Report, San Francisco*, San Francisco, CA, June 4, 2001.
[39] Charebois, E., et al., "HIV seroprevalence among homeless and marginally housed adults in San Francisco," Presented at the San Francisco HIV Consensus Meeting, Emeryville, CA, May 15-16, 2001.
[40] San Francisco Department of Public Health, *1998 Annual AIDS Surveillance Report*, San Francisco, CA, 1999.
[41] San Francisco Department of Public Health, HIV/AIDS Epidemiology Section, Op. Cit.
[42] Ibid.
[43] San Francisco Department of Public Health, Housing and Urban Health, *Evaluation of Direct Access to Housing Health Care Utilization and Housing Retention*, San Francisco, CA, August 2005.
[44] Diamond, P. & Schneed,, S., *Lives in the Shadows: Some of the Costs and Consequences of a "Non-System" of Care*, Hogg Foundation for Mental Health, University of Texas, Austin, TX, 1991.
[45] Calculation based on total 23,164 PLWHA the EMA as of 12/31/12 with a conservative annual homelessness rate of 7% (n=1,621) and a min. additional cost of $10,000 to meet these individuals' annual homeless-related needs.
[46] Percentage based on aggregated estimated uninsured rates for San Francisco, San Mateo, and Marin Counties provided in University of California, Los Angeles Center for Health Policy Research, *California's Uninsured by County: Results from the 2011 California Health Interview Survey*, Los Angeles, CA, February 2012.

[47] Estimate of total PLWHA living at 300% of poverty or below based on 100% rate of PLWH/A in CARE system living at or below 300% of poverty (n=7,290) plus conservatively estimated 51.6% rate of 300% at or below FPL for all other PLWA/H (same as overall EMA-wide rate) (15,875 PLWHA not in CARE system x .477 = 7,572).
[48] Calculation based on current annual projected EMA-wide HIV expenditures of $112,395,701 (see Table in Attachment 4) x .621, representing estimated percentage of all persons with HIV/AIDS living in poverty.
[49] Kittkraisak., W., et al, "Incarceration among young injectors in San Francisco: Associations with risk for hepatitis C infection," *Journal of Substance Use*, 11(4):271-278, August 2006.
[50] Calculation based on an estimated 10% of HIV cases among formerly incarcerated persons with HIV in San Francisco having been infected through unsafe drug and sex behaviors while incarcerated (n=102) at an average $12,000 per person per year.
[51] National Alliance of State and Territorial AIDS Directors (NASTAD), *National AIDS Monitoring Project Annual Report*, Washington, DC, July 2013, www.nastad.org/docs/NASTAD%20National%20ADAP%20Monitoring%20Project%20Annual%20Report.PDF
[52] All cost estimates in this section based on average cost per person of $14,605.81, adjusted based on complexity of care for each population. In the case of PLWHA 50 years of age and over the cost estimate is based on a per person cost of $20,000 for 11,230 total PLWHA age 50 and above with an estimated 80% in care rate (n=8,984).
[53] E.g., Herbst, et al., Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systemic review, *AIDS and Behavior*, 12(1):1-17, 2007.
[54] Clements, K., et al., HIV prevention and health service needs of the transgender community in San Francisco, *International Journal of Transgenderism*, 3(1+2), 1999.
[55] Clements-Nolle, K., HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention, *American Journal of Public Health*, 91(6):915-921, 2001.
[56] Bockting, W., Robinson, B., & Rosser, B., Transgender HIV prevention: A qualitative needs assessment, *AIDS Care*, 10(4):505-25, August 2998.
[57] Based on an estimated 500 total HIV-infected transgender persons of color x .75 in care rate (n=375) x estimated $15,000 cost per person.
[58] Based on estimated 6,529 total PLWHA MSM of color x .75 in care rate (n=4,897) x estimated $15,000 cost per person.
[59] Based on 1,621 total homeless PLWHA x .60 in care rate (n=973) x estimated $20,000 cost per person.
[60] Based on 3.042 total African American PLWHA x .70 in care rate (n=2,129) x estimated $18,000 cost per person.
[61] Based on 4,162 total Latino/a PLWHA x .75 in care rate (n=3,122) x estimated $18,000 cost per person.
[62] Source: Data from ARIES, San Francisco County's client database system
[63] Ibid.
[64] San Francisco Department of Public Health, HIV/AIDS Epidemiology Section, Op. Cit.
[65] Source: 2008 Comprehensive San Francisco EMA HIV Needs Assessment
[66] Ibid.
[67] Based on 2010 US Census data related to ethnic minority populations, applied to Latino and Asian/Pacific Islander HIV-infected populations.
[68] Based on total MSM PLWA/PLWHA populations in San Francisco EMA as of December 31, 2011 as a percentage of the total estimated self-identified gay/bisexual male population at approximately 5% of the EMA's total male population.
[69] Clements, K., Wilkinson, W., Kitano, K. & Marx, R., "HIV prevention and health services needs of the transgender community in San Francisco," *International Journal of Transgenderism*, 3(1), 1999.
[70] Source: 2008 Comprehensive San Francisco EMA HIV Needs Assessment
[71] The Healthy Communities Institute and the Hospital Council of Northern & Central California, *Health Matters in San Francisco: Hospitalization Rates due to Alcohol Abuse*, San Francisco, CA, 2010.
[72] California Department of Public Health, Drug-induced deaths ranked by three-year average age-adjusted death rate, California Counties, 2006-2008, *County Health Status Profiles 2010*, Sacramento, CA, July 2010.
[73] The San Francisco Injury Center, San Francisco Department of Public Health, *Profile of Injury in San Francisco 2004*, San Francisco, CA, 2002, December 2004.
[74] Heredia, C., "Dance of death, first of three parts: Crystal meth fuels HIV," *San Francisco Chronicle*, San Francisco, CA, May 4, 2003.
[75] Bajko, M., "Campaigns focuses on dark side of speed use," *Bay Area Reporter*, SF, CA, October 21, 2004.
[76] National Institute on Drug Abuse, *Addiction Science: From Molecules to Managed Care*, Rockville, MD, October 2012, http://www.drugabuse.gov/publications/addiction-science

[77] National Institute on Drug Abuse, *NIDA InfoFacts: Drug Addiction Treatment Methods*, Rockville, MD, November 5, 1999, www.nida.nih.gov/Infofacts/TreatMeth.html
[78] Sources: Ibid. & Memorandum from James Stillwell, San Francisco County Department of Public Health, September 9, 2005.
[79] Wong, J, "Pharmacoeconomics of Combination Therapy for HCV," Brief submitted at the Update on Liver Disease & Hepatitis Conference, February 2000.
[80] Harvard School of Public Health, "As Testing Campaigns Identify More People with Asymptomatic Hepatitis C Infection, Benefits, Risks, and Cost-Effectiveness of Early Treatment Uncertain," Cambridge, MA, July 8, 2003.
[81] Wong, J., McQuillan, G., McHutchison, J., & Poynard, T., "Estimating future hepatitis C morbidity, morality, and costs in the United States," *American Journal of Public Health*, Vol. 90, No. 10, October 2000.
[82] Source: California Health and Human Services Agency Tuberculosis Control Branch, *Report on Tuberculosis in California*, 2009, Sacramento, CA, August 2010, www.cdph.ca.gov/data/statistics/Documents/TB_Report_2009.pdf
[83] Sources: Ibid. & US Centers for Disease Control and Prevention, Division of Tuberculosis Elimination, "Reported Tuberculosis in the United States, 2004," *Surveillance Reports*, Atlanta, GA, September 2005.
[84] Rajbhandary, S., Marks, S., & Bock, N., "Costs of patients hospitalized for multidrug-resistant tuberculosis," *International Journal of Tubercular Lung Disease*, Vol. 8, No. 8, August 2004.
[85] Source: San Francisco Department of Public Health, Behavioral Health, estimates prepared for FY 2003 San Francisco EMA Ryan White Part A application.
[86] The San Francisco Injury Center, Op. Cit.
[87] Dilley, D. & Loeb, L., Op. Cit.
[88] Mayne, T., et al., "Depressive affect and survival among gay and bisexual men infected with HIV," *Archives of Internal Medicine*, 156(19), October 1996.
[89] Additional discrepancies between PLWA/PLWH numbers in the unmet needs estimate versus the EMA-wide epidemiological table (Table 1) include the following: a) The unmet needs estimate includes only PLWHA counts in eHARS or California State care databases, while the epidemiological table estimates PLWHA who are aware and unaware of their HIV status; and b) The unmet needs estimate includes PLWHA who were alive at any time from July, 2011 through June, 2012, while the epidemiological table includes only people living with HIV/AIDS as of December 31, 2012.
[90] Harder+Company Community Research, Op. Cit.
[91] Harder+Company Community Research, *Follow-Up Qualitative Study to the 2008 Needs Assessment: African American Women, Older Adults, Hepatitis C Co-Infected, and Providers*, San Francisco, CA, June 2010.
[92] Das M, Chu P, Santos G, Scheer S, Vittinghoff E, McFarland W, Colfax G, Decreases in community viral load are accompanied by reduction in new HIV infections in San Francisco, *PlosOne*, Vol. 5, Issue 6, June 2010.
[93] The White House Office of National AIDS Policy, Op. Cit.
[94] Ibid.
[95] Zellers, R., & Whitney, E., Op. Cit.
[96] U.S. Department of Health and Human Services, *Healthy People 2020*, Rockville, MD, July 2011.
[97] HRSA / US Centers for Disease Control and Prevention, *Number of Women, Infants, Children, and Youth Living with HIV/AIDS as a Percentage of All People Living with HIV/AIDS in EMAs/TGAs*, Data Period: Through 12/31/2008, Atlanta, GA, 2010.
[98] Pew Hispanic Center, *Demographic Profile of Hispanics in California, 2008*, Washington, DC, 2010, pewhispanic.org/states/?stateid=CA