THE YEAR IN REVIEW

SEPTEMBER 2014 – AUGUST 2015

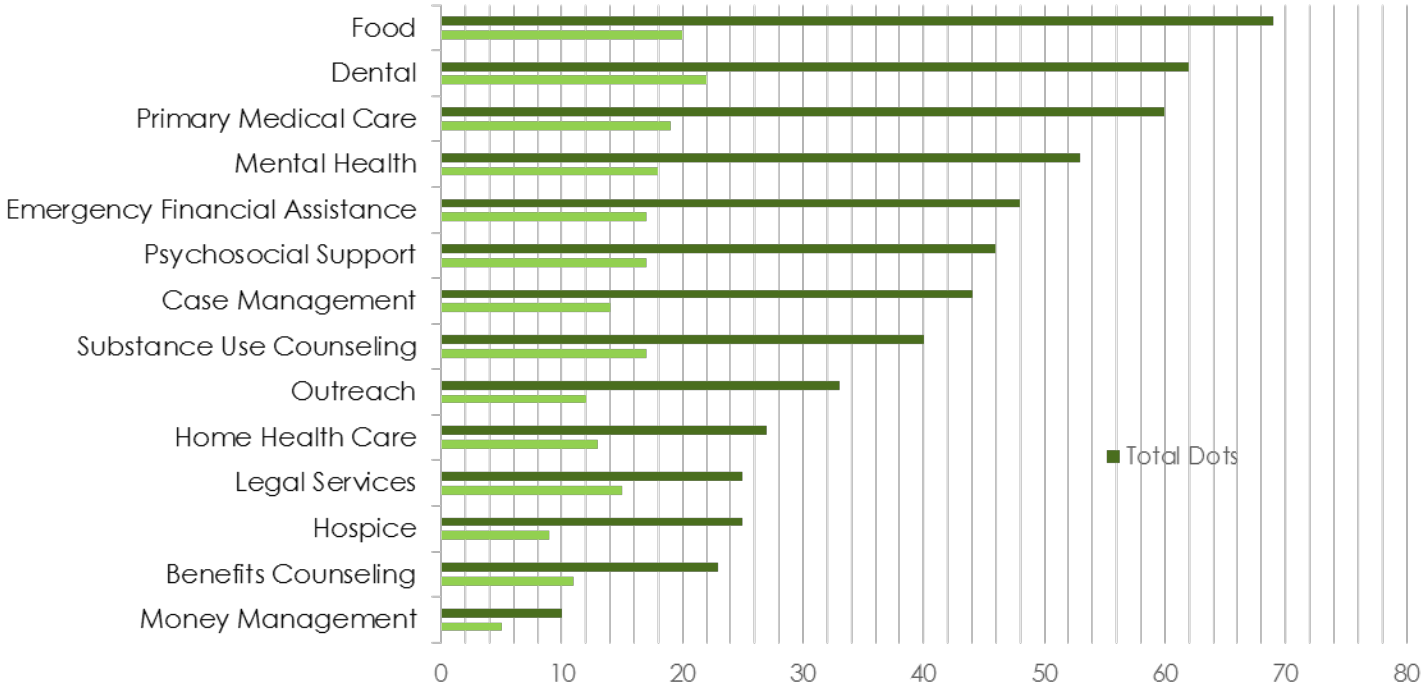
SEPTEMBER 2014

- Service Prioritization and Resource Allocation Summit
  - COLA Report
  - Needs Assessment Report
- CQI Report
- San Mateo Service Prioritization and Resource Allocation
- Marin Service Prioritization and Resource Allocation
- Minority AIDS Initiative Update
- Council Co-Chair elected: Chip Supanich
- SOA, HHS, CHEP & HPPC, Public Policy Updates

2013-2014 COLA SESSIONS

- **Asian & Pacific Islander MSM**
  - API Wellness Center
  - 10 participants
- **African American MSM**
  - San Francisco AIDS Foundation- Black Brothers Esteem
  - 15 participants
- **Living in SRO's**
  - Shanti Project
  - 8 participants

COLA Service Category Prioritization- Aggregate Results

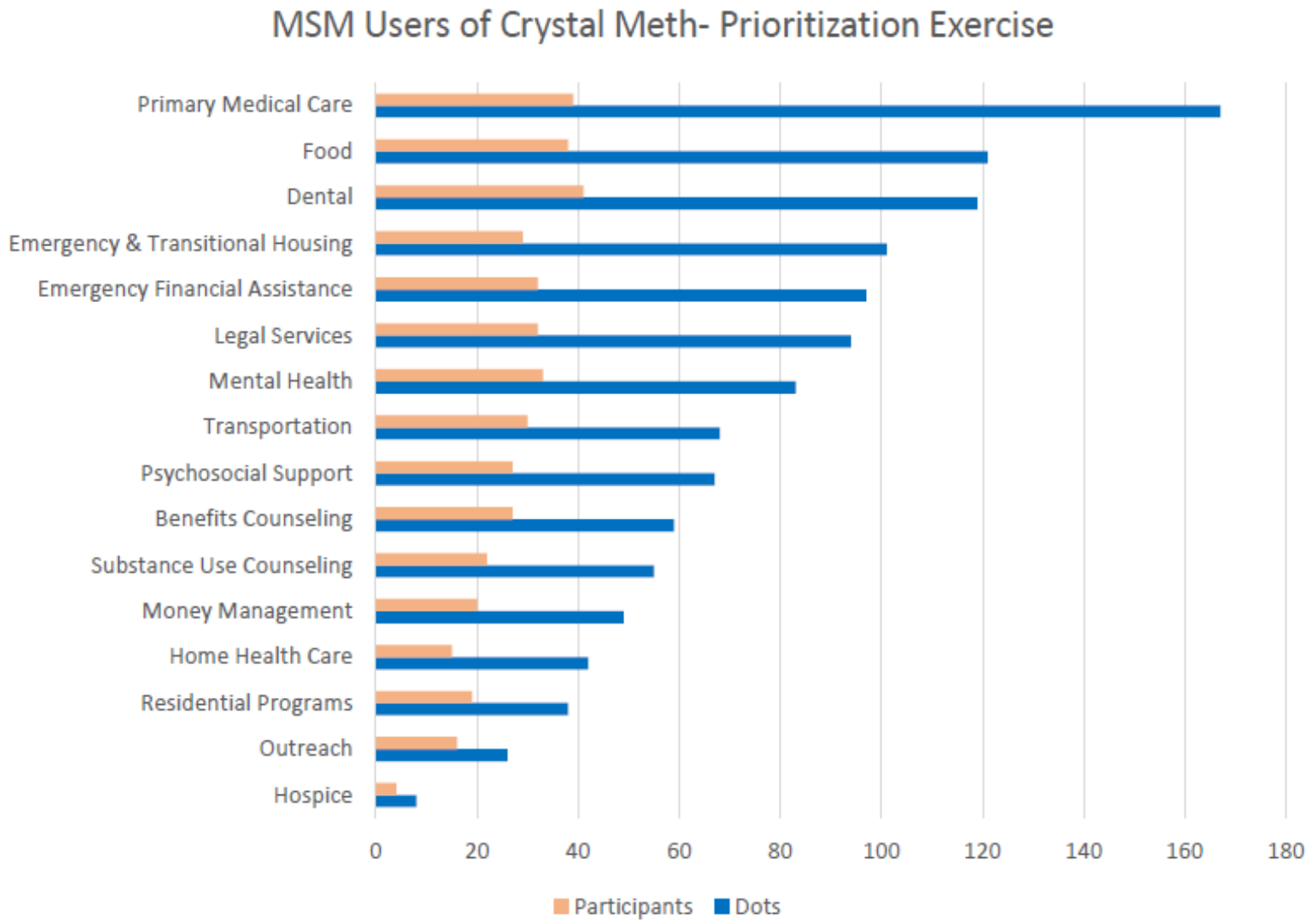


NEEDS ASSESSMENT: MSM USERS OF CRYSTAL METH

- 54 attendees participated in the seven focus groups taking place in San Francisco
- 54 questionnaires were completed by focus group participants
- Focus groups held at:
  - The Castro Country Club
  - San Francisco AIDS Foundation
  - St. Mary's Medical Center
  - Shanti
  - Tenderloin COE/API Wellness Center
- Follow-up groups to be scheduled in Marin and San Mateo

PRIORITIZATION EXERCISE

TOTAL RESULTS FROM SAN FRANCISCO N=52



NEEDS ASSESSMENT CONCLUSIONS

1. Due to the unique needs of the HIV-positive MSM population using crystal methamphetamine, HIV-specific substance use programs should be supported.
2. There continues to be challenges for clients regarding understanding the shifting benefits landscape. Expanded and ongoing distribution of the benefits tools created by the Health Reform Task Force may be considered.
3. As with many communities and demographics, navigation continues to be a key concern for MSM users of crystal methamphetamine. The most recent HIV Resource Guide was published in 2009; an updated version that includes online accessibility may be considered.
4. Mental Health is an ongoing challenge for this community. Additionally, mental health has been seen as a key service to support the reduction of substance use. Linkage between substance use and mental health programs should be considered a priority.
5. As with many communities and demographics, housing continues to be a key concern for MSM users of crystal methamphetamine, in particular in its relationship to health and safety.
6. Participants noted a continuing need for nutritional supplements (e.g. Ensure, Boost) that are no longer provided regularly or free of charge. Promoting easier access to these products (including use of vouchers) may be an area of review for the HHSPC.

SFEMA QUALITY MANAGEMENT PROGRAM - TRAININGS

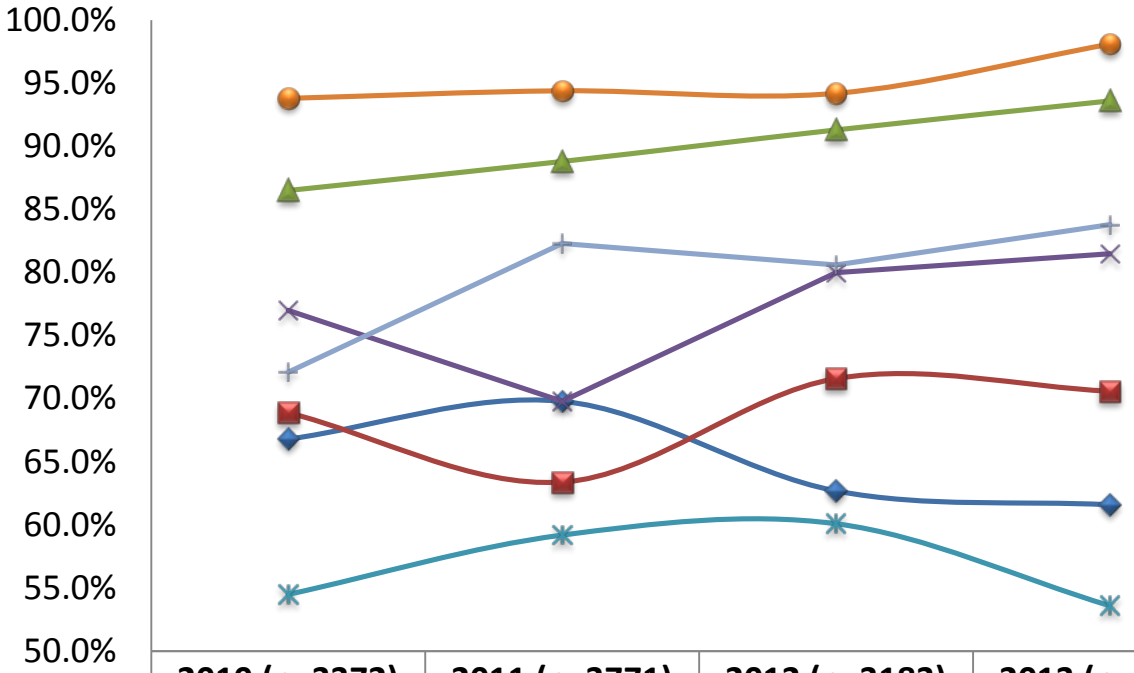
- De-Escalation
- Trauma-Informed Care
- Transgender Best Practices
- Leveraging Resources

SFEMA Quality Management Program – Collaborative Activities

Care Collaboration:

- Regional QM Meeting with San Francisco Clinic Consortium
- Integrating HIV testing and linkage to care in primary care sites
- Engage in Enhanced Comprehensive HIV Prevention Planning process to improve local compliance toward National HIV/AIDS Strategy

SF EMA PERFORMANCE INDICATORS 2010 - 2013



	2010 (n=3372)	2011 (n=3771)	2012 (n=3183)	2013 (n=3662)
Med. Visits	66.8%	69.8%	62.7%	61.6%
PCP Proph.	68.9%	63.4%	71.6%	70.6%
HAART	86.5%	88.8%	91.3%	93.6%
Hep C	77.0%	69.8%	80.0%	81.5%
Syphilis Screening	54.5%	59.2%	60.1%	53.6%
Viral Load Testing	93.8%	94.4%	94.2%	98.1%
Viral Load Supression	72.1%	82.3%	80.6%	83.8%

QUALITY MANAGEMENT PROGRAM – SUMMARY REPORT CONCLUSIONS

- HAART and Viral Load Testing indicators met or exceeded established thresholds.
- Hepatitis C Screening and Viral Load Suppression nearly met established thresholds.
- Medical Visits, PCP Prophylaxis and Syphilis Screening fell significantly below established thresholds.
- Health disparities does not appear to have a gender or race basis in the SF EMA primary care client pool.

Table 2. Demographics of Marin County Residents Newly Diagnosed with HIV Infection in the Community, 2008-2013

	Year of HIV Diagnosis	2008-09		2010-11		2012-13		Combined	
Gender	Male	31	82%	37	90%	20	91%	88	87%
	Female	7	18%	4	10%	2	9%	13	13%
Race/Ethnicity	Non-Hispanic White	21	55%	21	51%	7	32%	49	49%
	Hispanic/Latino	11	29%	14	34%	7	32%	32	32%
	Black/African American	4	11%	4	10%	6	27%	14	14%
	Asian	1	3%	1	2%	0	0%	2	2%
	Native Hawaiian/Pacific Islander	0	0%	1	2%	1	5%	2	2%
	Multiple races	1	3%	0	0%	1	5%	2	2%
Age at Diagnosis	13-19	0	0%	1	2%	0	0%	1	1%
	20-29	3	8%	10	24%	3	14%	16	16%
	30-39	14	37%	16	39%	6	27%	36	36%
	40-49	9	24%	6	15%	4	18%	19	19%
	50-59	8	21%	4	10%	7	32%	19	19%
	60+	4	11%	4	10%	2	9%	10	10%
Transmission Category	Male-Male Sexual contact (MSM)	18	47%	28	68%	15	68%	61	60%
	Injection Drug Use (IDU)	1	3%	2	5%	0	0%	3	3%
	MSM & IDU	5	13%	3	7%	0	0%	8	8%
	Heterosexual contact	5	13%	2	5%	0	0%	7	7%
	No Identified/Reported Risk	9	24%	6	15%	7	32%	22	22%
Late Testers*	No	20	53%	23	56%	15	68%	58	57%
	Yes	18	47%	18	44%	7	32%	43	43%
	Total	38	100%	41	100%	22	100%	101	100%

SERVICE CATEGORY			
CORE SERVICES	2012-2013	2013-2014	2014-2015
Outpatient/Ambulatory Health Services	$150,000	$129,704	$10,912
Mental Health	$92,000	$80,325	$60,000
Medical Case Management	$148,000	$132,668	$156,467
Home and Community-based Care	$45,500	$38,237	$38,000
Outpatient Substance Abuse Treatment	$6,000	$7,975	$0
Oral Health Care	$21,000	$5,689	$874
AIDS Pharmaceutical Assistance	$10,000	$12,000	$12,000
Health Ins Premium and Cost Sharing Assistance	$0	$0	$42,153
SUPPORT			
Non-medical case management	$108,000	$97,778	$100,000
Emergency Financial Assistance	$28,500	$29,263	$35,000
Food Vouchers	$10,000	$0	$0
Medical Transportation	$9,000	$8,476	$8,000
Residential Substance Abuse Treatment	$2,000	$0	$0
Total*	$635,033	$546,427	$467,906

*Table excludes a small portion of the total award for Council support

Characteristics of Newly Diagnosed HIV Cases, San Mateo County, 2009 - 2013[1]

	2009	2010	2011	2012	2013
Total Number	56	73	83	57	47
	Percent	Percent	Percent	Percent	Percent
Gender					
Male	84%	76%	90%	84%	92%
Female	14%	19%	10%	16%	6%
Transgender	2%	4%	0%	0%	2%
Age at Diagnosis					
0 - 19 Years	Not Available	2%	4%	0%	2%
20 - 29 Years	Not Available	28%	19%	28%	26%
30 - 39 Years	Not Available	28%	29%	18%	23%
40 - 49 Years	Not Available	30%	34%	40%	26%
50+ Years	Not Available	12%	14%	8%	23%
Race/Ethnicity					
White	34%	37%	29%	32%	32%
Black	9%	9%	11%	12%	6%
Latino/Hispanic	48%	34%	31%	35%	36%
Asian/Pacific Islander	7%	19%	28%	21%	19%
Multi-Race/Other/ Unknown	2%	0%	1%	0%	6%
Exposure Category					
MSM	51%	61%	57%	65%	70%
IDU	2%	4%	2%	2%	2%
Heterosexual Contact*	11%	8%	5%	17%	2%
MSM/IDU	5%	1%	6%	0%	0%
Other Risk/ Not specified	31%	25%	30%	16%	25%

Core Services	Previous Priority	New Priority	% Part A Allocation	Amount
Outpatient/Ambulatory Care*	1	1	34.90%	$412,970
Oral Health/Dental Care	2	2	7.60%	$90,000
Medical Case Management	3	3	33.53%	$396,790
Mental Health Services	4	4	9.30%	$110,069
Subtotal			**85.33%**	**$1,009,829**
Support Services				
Housing Services	1	1	0.94%	$11,129
Food Program	2	2	8.45%	$100,000
Medical Transportation*	3	3	0.00%	$0
Emergency Financial Assistance	4	4	5.28%	$62,495
Subtotal			**14.67%**	**$173,624**
Total			**100.00%**	**$1,183,453**

OCTOBER 2014

- Centers of Excellence Presentation
- SOA, HHS, CHEP & HPPC, Public Policy Updates

SAN FRANCISCO'S CARE MODEL
A COMPREHENSIVE SERVICE DELIVERY SYSTEM
CENTERS OF EXCELLENCE

- Design a system to respond to needs according to race, gender, geographic, linguistic and cultural needs for communities impacted by health disparities
- CoE offer integrated access to primary medical care and critical support services
- Allocated funding for CoE proportionate to client demographics
- Funding for models that offered innovative and effective approaches to reaching individuals not in care and bringing them into care and maintaining treatment and adherence to medication regimens over time
- Many CoE's represent a partnership between university, community, and public health service providers

COE'S CULTURALLY COMPETENT SERVICES

- 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 community center"** programs similar to medical homes with wraparound services
  - 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

- Centers of Excellence programs form a cost-effective system in which
  - **multidisciplinary teams** provide high levels of HIV specialist medical care
  - integrated with medical case management, mental health assessment, referral and/or brief counseling, substance abuse assessment, counseling and referral, treatment advocacy, psychiatric consultation and medication monitoring, care coordination, vouchers for transportation, clothing and household goods

REQUIREMENTS FROM 2010 COE SOLICITATION

- CoE model establishes primary medical care at the center of an integrated service delivery model that must provide at a minimum:
  - Primary Medical Care
  - Medical Case Management
  - Psychiatric Assessment and Psychiatric Medication Monitoring
  - Treatment Adherence and Medication Assistance
  - Outpatient Mental Health, Substance Use Assessment, Counseling and Referral

CENTERS OF EXCELLENCE

- Program located in Parnassus Heights and SFGH that addresses the medical and psychosocial needs of women with HIV within a chronic care model. Target population is women of color, recently incarcerated, and transgender women.
- Program located in the Mission targeting people of color particularly non-gay identified Latino men who have sex with men, Latina transgender women, with a special focus on severe need HIV-positive immigrants who are monolingual Spanish-speakers.
- Collaborative program with two key sites located in the Tenderloin area, with an emphasis on multiply-diagnosed individuals and harm reduction services. Target populations include homeless or marginally housed residents of the Tenderloin.
- Program providing services to individuals who are living in poverty and for whom mental health disorders, substance abuse, incarceration, or housing status create barriers to care. Primary care services provided at SFGH.
- Program providing services targeting African Americans living in the Southeast Corridor of San Francisco and throughout the City. Target population also includes any service-area residents who qualify as being “severe need” or part of a “special population”.
- Program providing services to individuals incarcerated in the San Francisco County jail system. San Francisco incarcerated adults are screened at intake for HIV status.
- Program located in the Mission and Mid-Market areas providing an array of services targeting Native Americans with a special emphasis on MSM.

NOVEMBER 2014

- HPPC Substance Use Work Group Presentation
  - HHSPC voted in favor of supporting recommendations from the HPPC Substance Use Work Group Transition Team Operating Agreements established
- Policy Update:

  Membership Committee's motions for renewal or nonrenewal will be brought to the next council meeting for discussion and vote. In the case no motion passes Membership, the item is added directly to the agenda of the Full Council, as motion to renew. If the motion to renew does not pass, the member is not renewed
- SOA, HHS, CHEP & HPPC, Public Policy Updates

HPPC SUBSTANCE USE WORK GROUP RECOMMENDATIONS

- **Recommendation 1**: Align principles and philosophy of harm reduction across all substance use treatment, HIV prevention and HIV care programs.
- **Recommendation 2**: Ensure that people who use alcohol and other substances have access to treatment and prevention programs that are grounded in the tenets of harm reduction. Recommit to a system of care that offers treatment on demand. Remove the structural barriers imposed by outmoded Civil service policies that prohibit programs from hiring qualified staff with specialized expertise.
- **Recommendation 3**: Ensure that people who use alcohol and other substance have access to evidenced based interventions for HIV prevention, substance use treatment and HIV care.
- **Recommendation 4:** Ensure that people who use alcohol and other substances have access to a system of care that is coordinated, cohesive, comprehensive, non-punitive and non-stigmatizing.
- **Recommendation 5:** Ensure that people in SF who use alcohol and other substance do not face criminalization as a result of substance use.

JANUARY 2015

- Residential Mental Health Presentation
- Psychosocial Support Presentation
- Needs Assessment: Asians and Pacific Islanders chosen as target for 2015 Needs Assessment
- Additional Needs Assessment: African-Americans
- SOA, HHS, CHEP & HPPC, Public Policy Updates

RESIDENTIAL MENTAL HEALTH

- Residential Mental Health Services has been part of the Ryan White funded system of care in San Francisco for many years, with one program funded to focus on women including Transgender women in the Tenderloin and South of Market.

- In addition, the multi-use facility in which the residential mental health services are provided, combines HOWPA and other funds. These include a separate behavioral health program and shelter services.

PRIORITIZATION & ALLOCATION SUMMIT - CONSIDERATIONS

- Few HIV-specific services available for these populations with the combined provision of housing and behavioral health services.
- Diminishes reliance on institutional in-patient programs or on homeless services such as shelters, which are short term compared to this program's 12 to 18 month length of stay.
- Continued need for additional residential services and care for long-term survivors who develop cognitive impairment.

PSYCHOSOCIAL SUPPORT

- In 2007, HRSA redefined many of the activities which are now categorized under Psychosocial Support Services. With the elimination of "Peer/Client Advocacy" and "Treatment Advocacy" services categories, HIV Health Services placed practical & emotional support, peer support groups and social activities into the expanded definition of Psychosocial Support service category.
  - Many of the components of "Peer Advocacy" such as education of and referral to HIV services community resources, treatment readiness, and dealing with feelings of isolation, depression and stigma within a "peer" setting transferred into Psychosocial Support service category.
- Psychosocial support services has been part of the HHSPC Ryan White funded system of care for many years. Due to the uniqueness of program services and target populations, these services were separately put out to bid (RFP'd) in 2008 and 2012.
- Mental health service agencies may provide Psychosocial support groups and do so under mental health service category or through "private funding". These services are often not reported in ARIES as a psychosocial support service.

HHS PROGRAM DESCRIPTIONS

- Program provides a collaborative support group for HIV positive heterosexually identified African American men; recruitment and outreach takes place by case managers, peer advocates or other sources. This group is available to all clients self-identifying as part of the target population. The group is facilitated by a mental health professional, with a flexible structure.
- Program provides a range of psychosocial support interventions including emotional support and practical assistance, groups and educational opportunities, a drop-in center, an activities and events program, client advocacy and care navigation, health counseling, and volunteer peer support. Other services that promote continued engagement in care, with an emphasis on individuals: 1) living on fixed and low incomes; 2) are socially isolated; 3) are “aging” or senior population; 4) are physically impaired; and 5) have severe need.

PRIORITIZATION & ALLOCATION SUMMIT - CONSIDERATIONS

- Psychosocial Services is a key access/entry point for the newly diagnosed and those individuals new to San Francisco.
- Assists a wide range of clients hailing from an equally wide range of communities – many of whom do not have other forms of peer-based support and/or come from communities with historical challenges in engaging with the traditional medical model of care.

FEBRUARY 2015

- Robert's Rules of Order Training
- HIV Criminalization Presentation
- Presentation on HHSPC Merge Motions and HPPC Merge Recommendations
- HHSPC voted to extend committee assignments through January 2016
- SOA, HHS, CHEP & HPPC, Public Policy Updates

Decriminalization Efforts

- Problems with HIV criminalization laws
  - Contributes to HIV-related stigma
  - Negatively impacts LGBT populations
  - All do not follow standard criminal law principles of requiring intent to harm
  - Results in disproportionate penalties
  - Defeats public health messages about HIV
  - Are unsupported by research

Proposed changes in CA

- Adopt DOJ's Best Practices recommendations to reform HIV-specific criminal laws
  - Eliminate HIV-specific criminal penalties.
  - Require knowledge, intent, conduct that poses a risk of transmission, and actual transmission.
  - Modernize outdated CA law with *contemporary scientific knowledge* of acquisition and transmission of HIV.
- Solicitation while HIV-positive.
  - Repeal felony sentence enhancement for solicitation while HIV-positive.
- HIV exposure and testing.
  - Repeal felony HIV exposure statute & accompanying testing provision.
- Sex offense committed while HIV-positive.
  - Repeal existing 3 year enhancement that is specific to PLHIV.

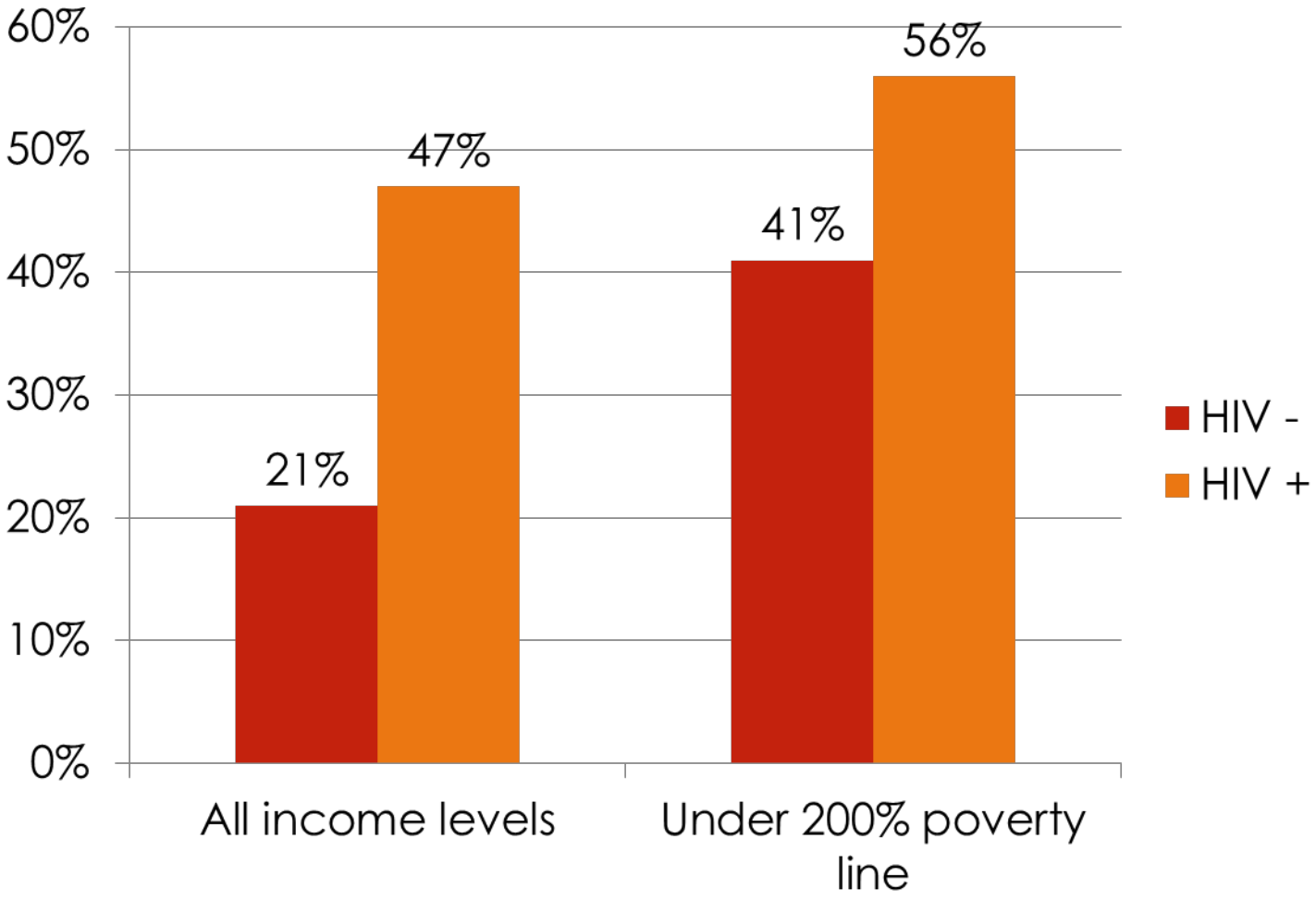
HHSPC	HPPC
▪ **Any collaboration or merger between Prevention and Care shall guarantee representation such that all membership standards, leadership roles, and meetings shall include at least 33[1]/3% HIV positive non-affiliated consumers.** ▪ **In the event of a merged council, county government representatives from San Mateo and Marin will be allocated one voting seat per county.** ▪ **In the event of a merged council, all council leadership positions, including workgroups and committees, must be voted on.** ▪ **In the event of a merged council, all council members from the HHSPC and HPPC would retain their seat. As members leave the council, or are not renewed, their seats would not be filled until the merged council falls below a maximum of 45 members.** ▪ **In the event of a merged council, work towards implementation shall begin Jan 1, 2015.** ▪ **To accept Exhibit A as a transitional framework for a committee structure and exhibit B as a final framework, both being subject to change.**	Priorities & Processes are based on: ▪ Epi data ▪ Science based evidence ▪ Knowledge & expertise ▪ Community lens & voice Policies & Procedures for Operation should include: ▪ Monthly meetings ▪ Term limit for members ▪ Members reapply to new council Co-chairs of the Council should include: ▪ Government Representative ▪ People living with HIV/AIDS ▪ HIV negative people at high risk for HIV Representation on the Council should include: ▪ HIV negative people at high risk for HIV ▪ People living with HIV ▪ Substance use providers including harm reduction ▪ Representatives from City departments that have expertise in mental health/substance use, housing, STD, incarcerated population, TB, PrEP, and HIV ▪ Representative from jurisdictional partners (Marin and San Mateo) who vote ▪ Hospital representative ▪ Youth <25 years old

HHSPC	HPPC
▪ **In the event of a merged council, all council leadership positions, including workgroups and committees, must be voted on.** ▪ **In the event of a merged council, all council members from the HHSPC and HPPC would retain their seat. As members leave the council, or are not renewed, their seats would not be filled until the merged council falls below a maximum of 45 members.** ▪ **To accept Exhibit A as a transitional framework for a committee structure and exhibit B as a final framework, both being subject to change.**	Policies & Procedures for Operation should include: ▪ Term limit for members ▪ Members reapply to new council Co-chairs of the Council should include: ▪ Government Representative ▪ HIV negative people at high risk for HIV Representation on the Council should include: ▪ HIV negative people at high risk for HIV ▪ Representatives from City departments that have expertise in STD, TB, and PrEP

MARCH 2015

- Food Insecurity and Food Services Presentation
- Health Promotion with Crack Smokers Presentation
- Eligibility Criteria and Severe Need & Special Populations Update
- SOA, HHS, CHEP & HPPC, Public Policy Updates

PLWH HAVE HIGHER RATES OF FOOD INSECURITY

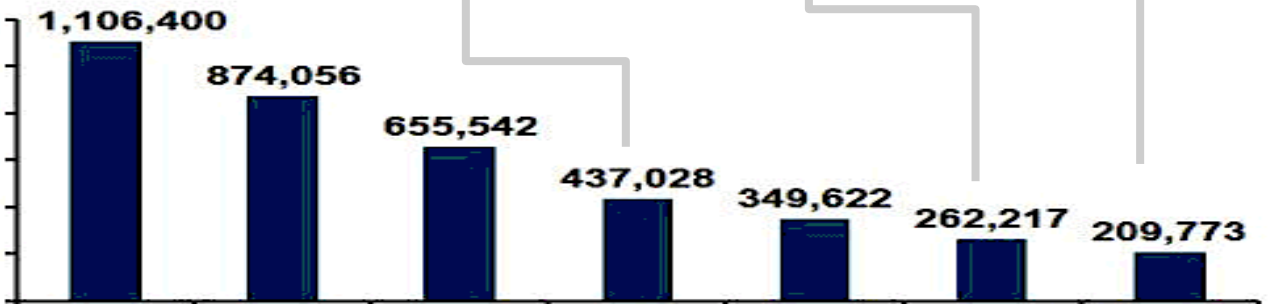


Source: Palar, Weiser et al (draft) National Health and Nutrition Examination Survey 1999-2008

FOOD INSECURITY HAS IMPACTS ALONG THE HIV CASCADE OF CARE

Food insecure patients are…

* More likely to be HIV-infected [a]
* More likely to miss clinic visits and be lost to follow up [b]
* More likely to have lower ART adherence [c]
* More likely to have lower VL suppression [d]
* More likely to die earlier from HIV/AIDS [e]



HIV infected
HIV diagnosed
Linked to care
Retained in care
Need ART
On ART
Undetected VL
Longevity

a Vogenthaler 2012; b Weiser, 2012; Nash 2010;
c Kalichman 2011; d Wang 2011; e Weiser 2009.

CRACK SMOKING & HEALTH

- Oral Sores & ulcers
- Burns
- Respiratory Injuries & Infections
- “Driver" of HIV & accelerated disease progression
- HCV, HBV
- STIs
- Tuberculosis

Baum, et al. 2009; Booth, et al. 2000; Centers for Disease Control and Prevention 1991; DeBeck, et al. 2009; Edlin, et al. 1994; Faruque, et al. 1996; Feldman, et al. 2000; Fischer, et al. 2008; Gordon and Lowy 2005; Haim, et al. 1995; Jones, et al. 1998; Kim, et al. 2013; Macías, et al. 2008 ; Meleca, et al. 1997; Rosenberg, et al. 2001; Story, et al. 2008; Tortu, et al. 2004; Wilson, et al. 1998

HEALTH DISPARITIES & STIGMA

Synergistic Factors:

- Addiction
- Illegality
- Poverty
- Stigma & Marginalization
- Public Health & Criminal Justice Systems
- Pervasive demonization
  - Sexism
  - Racism
  - Classism

CONCLUSIONS

- Distributing harm reduction materials to crack smokers creates opportunities
  - To reduce stigma
  - To engage & connect
  - To educate and support
- a high-risk, underserved population
- Crack pipe Distribution
  - Directly address associated health risks
  - Helps de-stigmatize/de-demonize crack
  - Further incentivize interaction with harm reduction services
  - Augment & increase client participation
  - Facilitate holistic benefits of harm reduction during the continuum of drug use

APRIL 2015

- Food Task Force Presentation
- Transition Team motions approved by HHSPC:
  - **To form a Joint Steering/Executive Committee that consists of 13 members from the HHSPC with eight votes (three Council Co-Chairs with individual votes, six representatives from the Subcommittee Co-Chairs each having one vote per subcommittee and four At-large Members sharing two votes) and up to eight representatives from the HPPC (the current five Executive Committee Members and an additional three At-large Members)**
- Joint Leadership Work Group Operating Agreements approved by HHSPC
- Eligibility Criteria and Severe Need & Special Populations Update
- SOA, HHS, CHEP & HPPC, Public Policy Updates

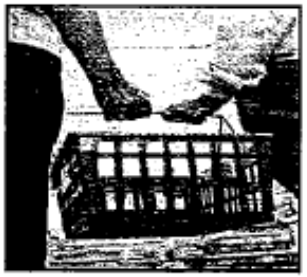
Food *Insecurity* in San Francisco

- Food *Insecurity* exists when the ability to obtain and prepare nutritious food is uncertain or not possible

- < 200% of poverty – highest risk for food insecurity
  - 1 in 4 San Franciscans
  - Federal poverty measures are not adjusted for local conditions
  - Every district in San Francisco has food insecure residents

Food Resources

- Income insufficient
  - High-cost of living in SF – poverty definition not indexed
  - More than 1 in 4 lives below 200% poverty ($40K for a family of 3)
- CalFresh highly effective but under-enrolled
  - State: CA ranked last in U.S. for participation
  - SF: ~ 51K individuals; estimated 50% of eligible are enrolled
  - Benefit not adjusted (now-$1.40/meal)
- Many San Franciscans are ineligible for CalFresh
  - 45K SSI recipients: low-income seniors, disabled adults – current SSI/SSP grants to individuals ~90% of FPL ($889/mo)
  - Undocumented residents
  - Gross income > 130% FPL ($25K for family of 3)



Challenges

Eligibility

- Have a low income, defined as an annual federal adjusted gross income equal to or less than 400% of the Federal Poverty Level (FPL), which for 2015 is **$47,080** for one person.

Severe Need

- Poverty, defined as an annual federal adjusted gross income equal to or less than 150% of FPL (Federal Poverty Line), which for 2015 is $**17,655** for one person or **$23,895** for two people.

MAY 2015

- ❑ HCAP Annual Report
- ❑ US PrEP Demonstration Project Presentation
- ❑ PrEP Health Program Presentation
- ❑ HHSPC voted to approve request for 75/25 waiver
- ❑ SOA, HHS, CHEP & HPPC, Public Policy Updates

☑ Consumer & Community Affairs Committee completed its review of the Standards of Care and Best Practices for all services categories. 👍

HCAP clients sought assistance across the spectrum of service categories, with the majority of cases in the housing, case management, and primary medical categories.

SERVICE CATEGORY

Service Category	Percentage of Cases [7]	2013	2012
Housing	32%	22%	29%
Case Management	27%	17%	12%
Primary Medical	15%	24%	9%
Mental Health	11%	7%	8%
Dental	8%	11%	19%
Food	7%	2%	8%
Social Support	7%	4%	0%
Emerg. Financial Assist.	6%	4%	7%
Benefits Counseling	3%	1%	0%
Substance Use	3%	2%	4%
Hospice	0%	1%	0%
Money Management	0%	4%	4%

The following chart is an overview of the types of issues that consumers brought to HCAP. Many clients have more than one issue.

Type of Issue	Percentage of Cases	2013	2012
Problematic Policy or Procedures	23%	17%	11%
Quality of Care	22%	16%	12%
Access	15%	11%	11%
Miscommunication	15%	13%	19%
Termination From Services	12%	6%	9%
Failure to Observe Procedures	10%	2%	4%
Eligibility	8%	4%	7%
Failed Negotiations with Regard to Grievance/Complaint	8%	2%	2%
Non-Engagement with Regard to Grievance/Complaint	8%	2%	7%
Assistance Sought by Provider	7%	4%	7%
Cultural Sensitivity	7%	3%	5%
Confidentiality	6%	2%	2%

SFDPH PREP NAVIGATION SERVICES AT SF CITY CLINIC

- Since May 2014, provided PrEP navigation to 450 clients and initiated >120 on PrEP
- 36% had previously received nPEP at the clinic
- 40.5% had a history of a syphilis, rectal gonorrhea or chlamydia in the prior year
- 43% insured (65% Medicaid, 35% other)
- 57% uninsured and enrolled in a medication assistance program (MAP)
- 38% of uninsured clients have enrolled in health insurance
- Younger and more diverse than Demo cohort

SFDPH PREP NAVIGATION SERVICES AT SF CITY CLINIC

	Demo Cohort (SFCC)	Clinic Cohort (SFCC)
Mean age	36	32
% < 26	15	25
Race/Ethnicity		
White	62	43
Black	3	8
Latino	21	29
Asian	6	15

PREP DEMO PROJECT: LESSONS LEARNED

- High demand for PrEP
- Very good retention and adherence, but with variation by race/ethnicity, site, and sexual risk
- Low HIV incidence, high STI incidence
- Feasible to deliver in an STD clinic setting
- High levels of interest in continuing PrEP -- addressing PrEP access issues is critical

PREP AT MAGNET

Enrollment

260 PrEP Screen
239 Enrolled (92%)
21Not Eligible/Incomplete Screen(8%)

JUNE 2015

- Essential Health Benefits Presentation
- Benefits Training Project Report-back
- Aging Support Project Report-back
- SOA, HHS, CHEP & HPPC, Public Policy Updates

For success in fighting the HIV epidemic, comprehensive services for PLWH must include:

- Ambulatory patient services (primary care; outpatient medical care)
- Emergency services
- Hospitalization (in-patient care; e.g. surgery, overnight hospitalization)
- Residential care facilities for the chronically ill
- Hospice care
- Home health care
- Rehabilitative services and durable medical equipment (e.g., physical therapy, assistive devices)
- Preventive and wellness services (e.g., physical and mental health screenings, wellness counseling, immunizations)
- Pregnancy care and family planning for women and men (preconception, safer conception)
- HIV-exposed newborn services, pediatric, and adolescent HIV care
- Laboratory services
- Prescription drug coverage
- Mental health and substance-related disorder services (counseling, psychiatry, in-patient/residential, medical detox, out-patient treatment)
- Dental care
- Case management, referral, and navigation services (medical and non-medical; support with linkage to and coordination of medical care and support services; chronic disease management)
- Employment services
- Psychosocial support for emotional well-being (structured peer counseling, education, navigation, and referral; support groups, activity groups, volunteer services)
- Peer advocacy and education
- Benefits counseling
- Money management
- Legal services (consultation, referral, and representation on civil matters such as housing, immigration, insurance, access to health care, and public benefits)
- Housing support (emergency stabilization housing, transitional housing, rental subsidies)
- Nutritional therapy, dietary education, food pantry, and delivered meals
- Emergency financial assistance
- Transportation support (affordable mass transit, paratransit, taxi and emergency transportation)

GOAL OF TRAINING

The goal of the Medical Benefits Counseling Training Project is to perform provider trainings and community information sessions related to healthcare access and other benefits issues with an emphasis on older adults living with HIV/AIDS

- Project started in late 2011
- First event on February 29, 2012: "MBC Pilot Training Session"
- Topics focused on the Affordable Care Act, Medicare, and income benefits
- From February 2012 to June 2015, 44 training events were completed.

CONTENT OF TRAININGS

- Healthcare Reform (The Affordable Care Act) – Covered in 16 sessions
- HIV and Aging Update – Covered in 11 sessions
- MAGI Medi-Cal (Medicaid Expansion) – Covered in 15 sessions
- Medicare – Covered in 16 sessions
- SSI/SSDI – Covered in 26 sessions
- Ryan White/ADAP – Covered in 7 sessions
- Covered California – Covered in 15 sessions
- Cash Assistance Program for Immigrants (CAPI) – Covered in 4 sessions
- Office of AIDS programs such as OA-HIPP & ADAP – Covered in 7 sessions
- Accessing Healthcare – Covered in 17 sessions
- Return to Work Rules for Social Security – Covered in 23 sessions (ongoing)
- Private Long Term Disability Policies – Covered in 14 sessions
- Effects of Same Sex Marriage on benefits – Covered in 3 sessions

Target audience:

Long-Term Survivors of the AIDS epidemic

- people who are HIV+
- over 50 years old

Target UDC: 50 – exceeded goal by 36% (N=68)

Linkage to individual psychosocial support:
Care Navigation
Volunteer Peer Support
Peer Health Counseling

Town Halls (N=4)

Targeted Shanti group-level programming
"Special invitation to LTS"

WEEKLY
Coffee-Chat
Group Exercise (7-week series)
Planning Meetings (bi-monthly)

JULY 2015

- Service Category Review
- HIV Epidemiology Report
- ARIES Report
- LTCCC Representative approved: TJ Lee
- SOA, HHS, CHEP & HPPC, Public Policy Updates

SERVICE CATEGORY REVIEW

- Home Health Care
- Home and Community-based health Services
- Psychosocial Support
- Residential Mental Health
- Outreach
- Referral for Healthcare/Supportive Services
- Housing: Facility-based Care

Home Health Care

Definition of unit of service:

- Attendant Care Day
- Homemaker Service Day
- RN/MSW Professional Visit
- Specialized Patient Day
- RN/MSW/OT/PT/ST Professional Visit
- Home Health Aide Paraprofessional Visit

Home and Community-based Health Services

Definition of unit of service:

- Certified Nursing Assistant/Home Health Aide Care Day
- Homemaker Paraprofessional Service Day
- RN/MSW Professional Visit

Outreach

Target Population

Low income, uninsured, HIV positive Latino immigrants, at or below poverty level: special focus on monolingual Spanish speakers: high risk sub groups include gay, bisexual, transgender, injection drug users, other substance users, and sex partners of above.

Description of Service

Treatment Outreach - Individual: individual outreach activities in places where the target population lives and/or socializes such as street based contacts, client education and information tables.
Treatment Outreach - Groups: distribution of information outside bars, educational presentations at community events and gatherings, advocacy of diagnosis and treatment options, referral to testing and other services as needed.
Treatment Education, Linkage and Follow-up: provision of information on treatment options, and treatment adherence support services; education on health improvement and motivation counseling to access care and treatment; referral and linkage into services and follow-up services

REFERRAL FOR HEALTHCARE/ SUPPORTIVE SERVICES

Description of Service

This program provides:

Non- Medical Case Management -- intake, assessment, care planning, follow up and monitoring, reassessment, transfer and discharge, and some linkage to housing;

Financial Benefits Counseling – defined as the provision of specialized assistance (information, referral, and benefits counseling) to the client regarding entitlement programs availability and eligibility.

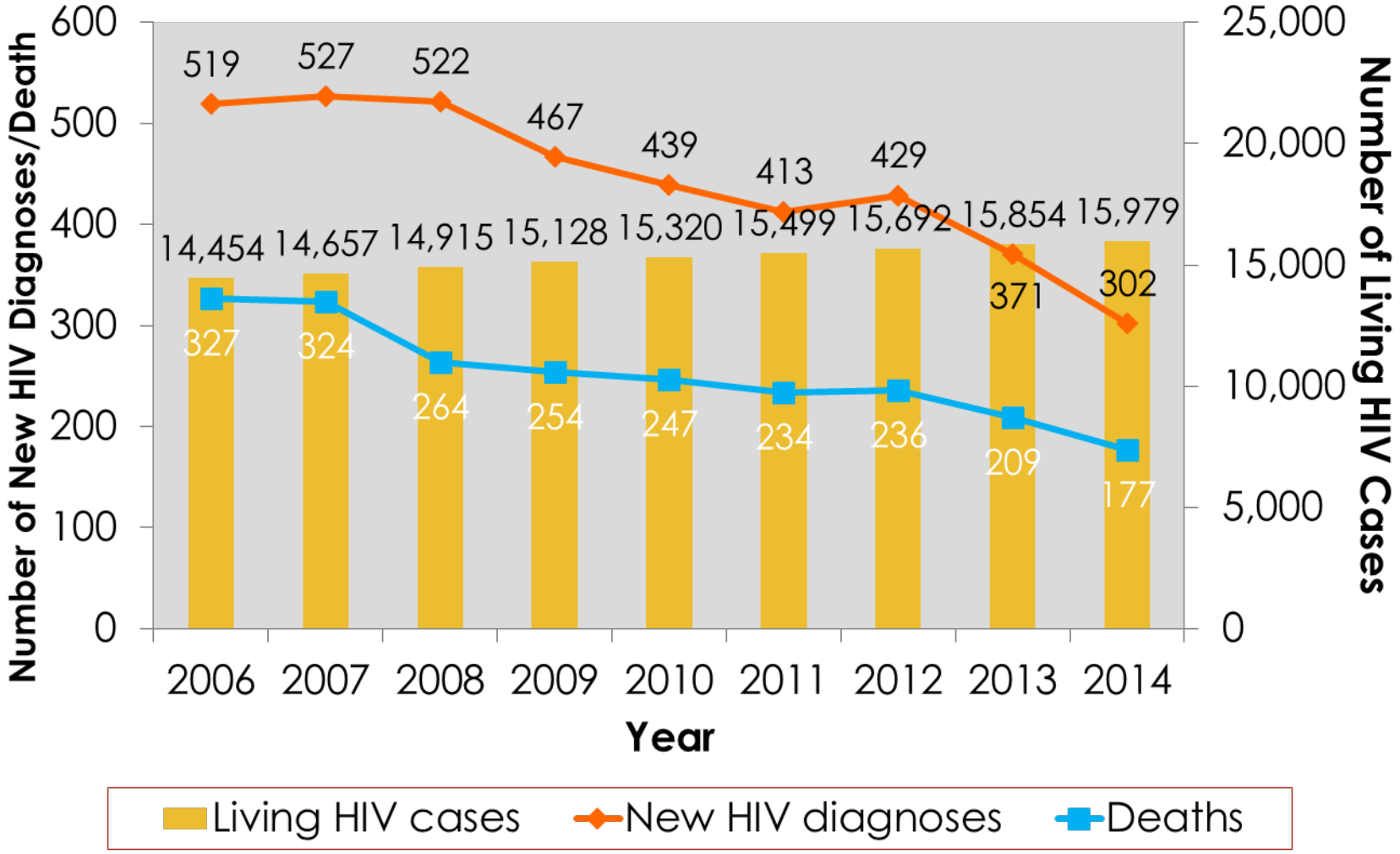
This program is located between the Tenderloin/SOMA areas.

HOUSING: FACILITY-BASED CARE

Funding almost exclusively pays for the cost of CNAs (Certified Nurse Assistants) RNs who provide basic attendant care and nursing care for PLWH who live in three RCFCIs (Residential Care Facility for the Chronically Ill). The majority of the funding is for the CNAs who are on site 24 hours.

Certified Nursing Assistants (CNA's) are available to provide assistance to residents 24 hours per day, 7 days per week. Under direction of a Registered Nurse, the CNA's help residents with activities of daily living including bathing, dressing, oral hygiene, housekeeping, monitor vital signs, report on residents' medical conditions, Maintenance of patient charts, Accompany residents to medical appointments, Assist in emergency medical situations. Assist LVN's and RNs when appropriate. Maintain standards of infection control and blood borne pathogens. In addition, the CNA's assist residents with self-administered medications and observe for and report changes in health status to the RN Case Managers. If residents are in the final phase of their lives and in need of more care the RN Case Manager arrange to increase staffing to ensure their safety and comfort.

NEW HIV DIAGNOSES, DEATHS AND PREVALENCE 2006-2014 SAN FRANCISCO

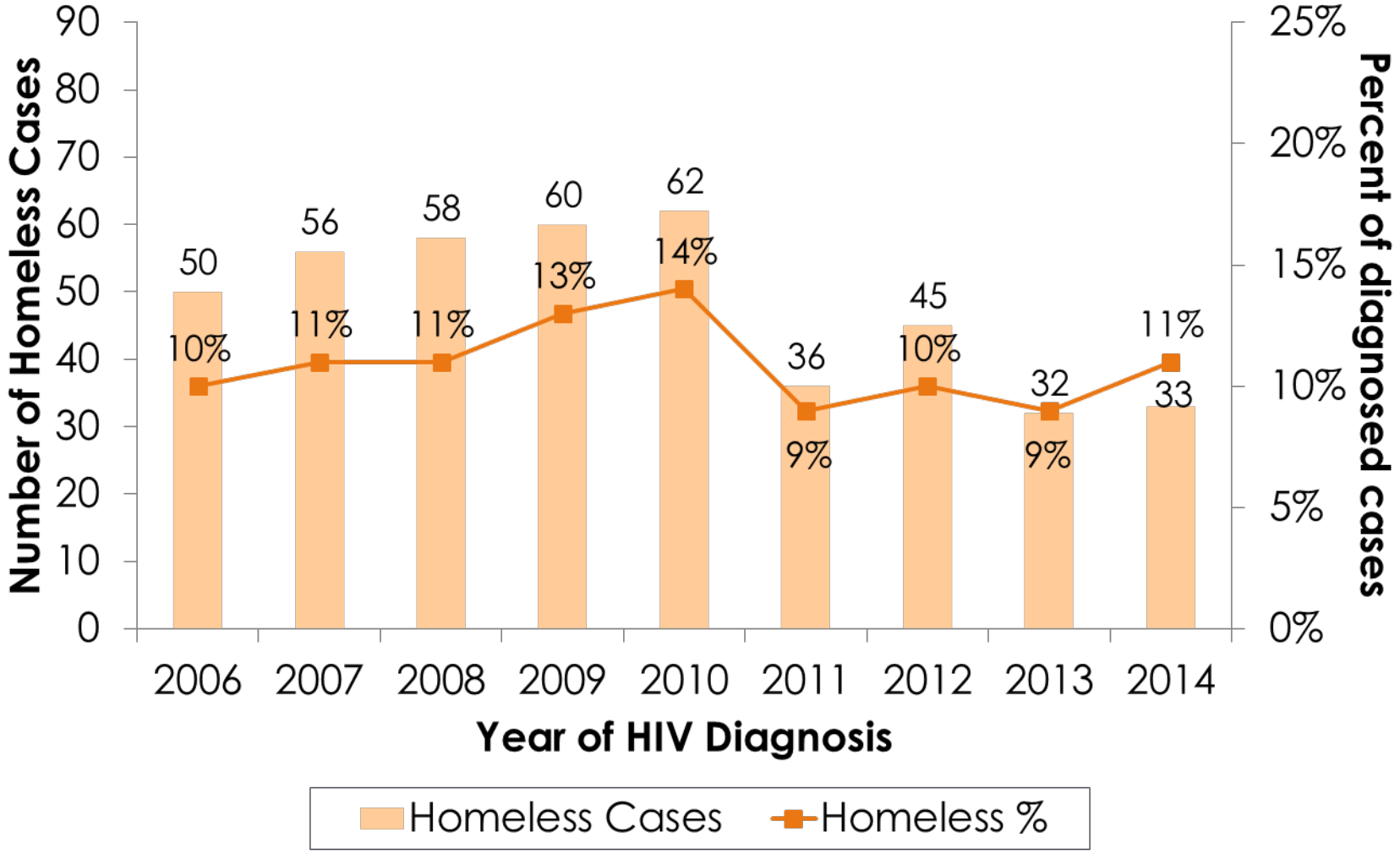


CHARACTERISTICS OF PERSONS LIVING WITH HIV

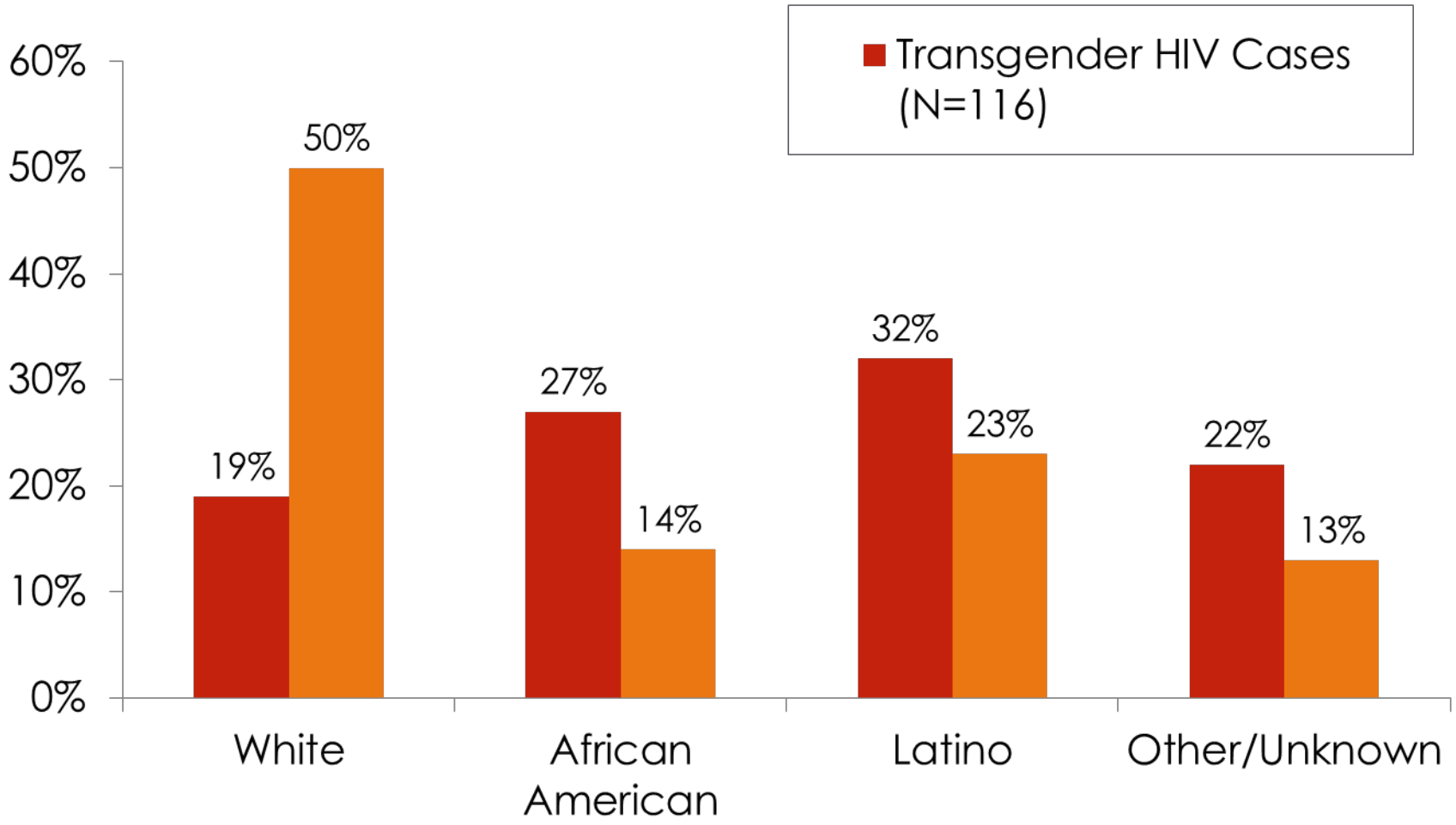
	PLWH (N=15,979)		HIV DX in 2006 (N=519)		HIV DX in 2014 (N=302)	
	Number	%	Number	%	Number	%
Gender						
Male	14,722	92%	469	90%	282	93%
Female	901	6%	36	7%	14	5%
Transgender	356	2%	14	3%	6	2%
Risk						
MSM	11,787	74%	365	70%	226	75%
MSM PWID	2,423	15%	81	16%	34	11%
PWID	951	6%	39	8%	19	6%
Heterosexual	526	3%	24	5%	8	3%
Other/Unidentified	277	2%	10	2%	15	5%

	PLWH (N=15,979)		HIV DX in 2006 (N=519)		HIV DX in 2014 (N=302)	
	Number	%	Number	%	Number	%
Race/Ethnicity						
White	9,708	61%	278	54%	136	45%
African American	2,014	13%	75	14%	33	11%
Latino	2,894	18%	113	22%	82	27%
API/Native Amer.	986	7%	36	7%	39	13%
	Current Age (as of 12/2014)		**Age at Diagnosis**			
< 30 years	582	3%	128	25%	87	29%
30-39 years	1,837	12%	175	34%	91	30%
40-49 years	4,358	27%	143	28%	73	24%
50-59 years	5.806	36%	56	11%	38	13%
60-64 years	1,860	12%	10	2%	12	4%
65+ years	1,536	10%	7	1%	1	<1%

Trends in Number and Percent of Diagnosed Cases Homeless at Time of Diagnosis, 2006-2014



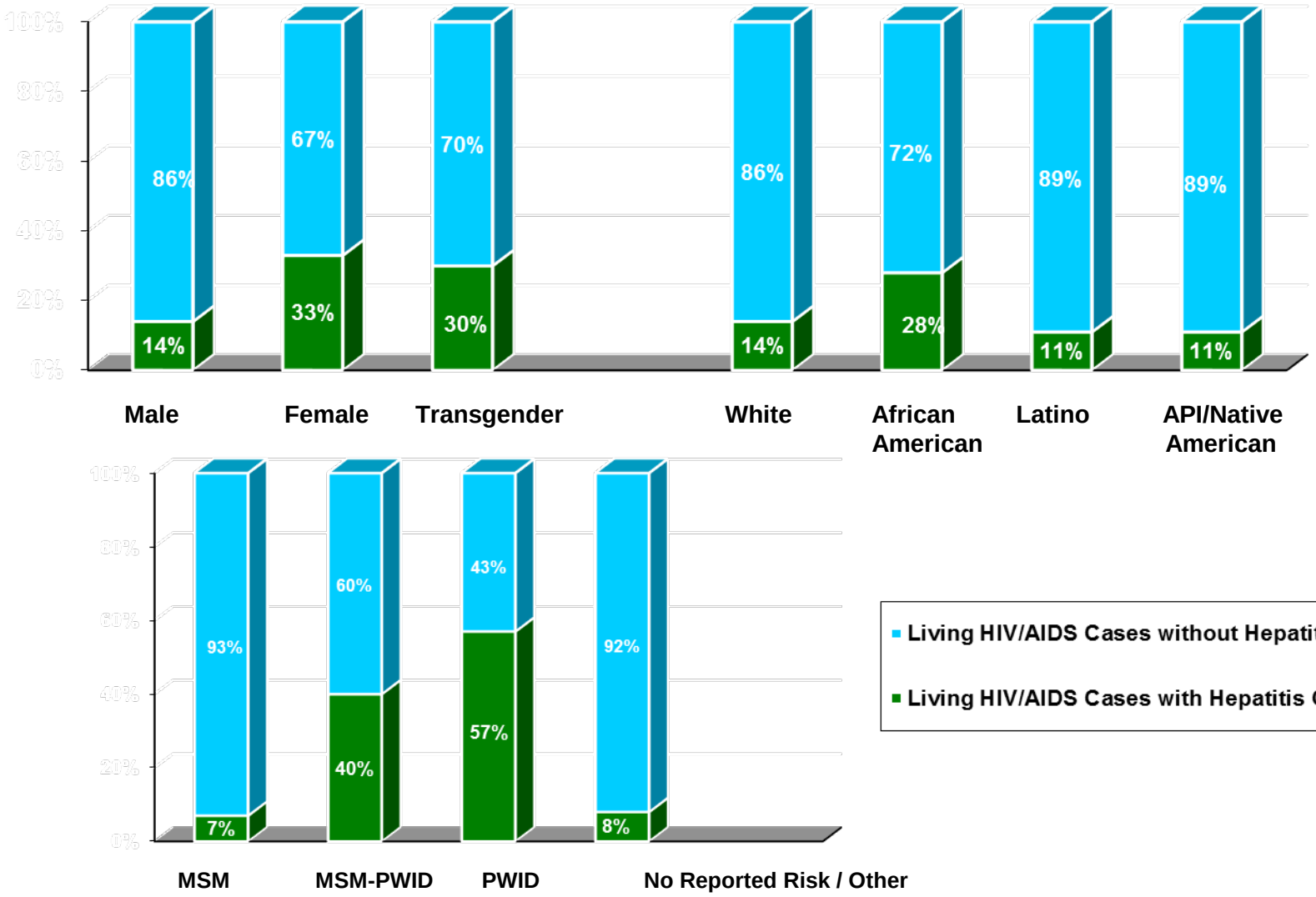
CHARACTERISTICS OF TRANSGENDER AND HIV CASES, DIAGNOSED 2006-2014



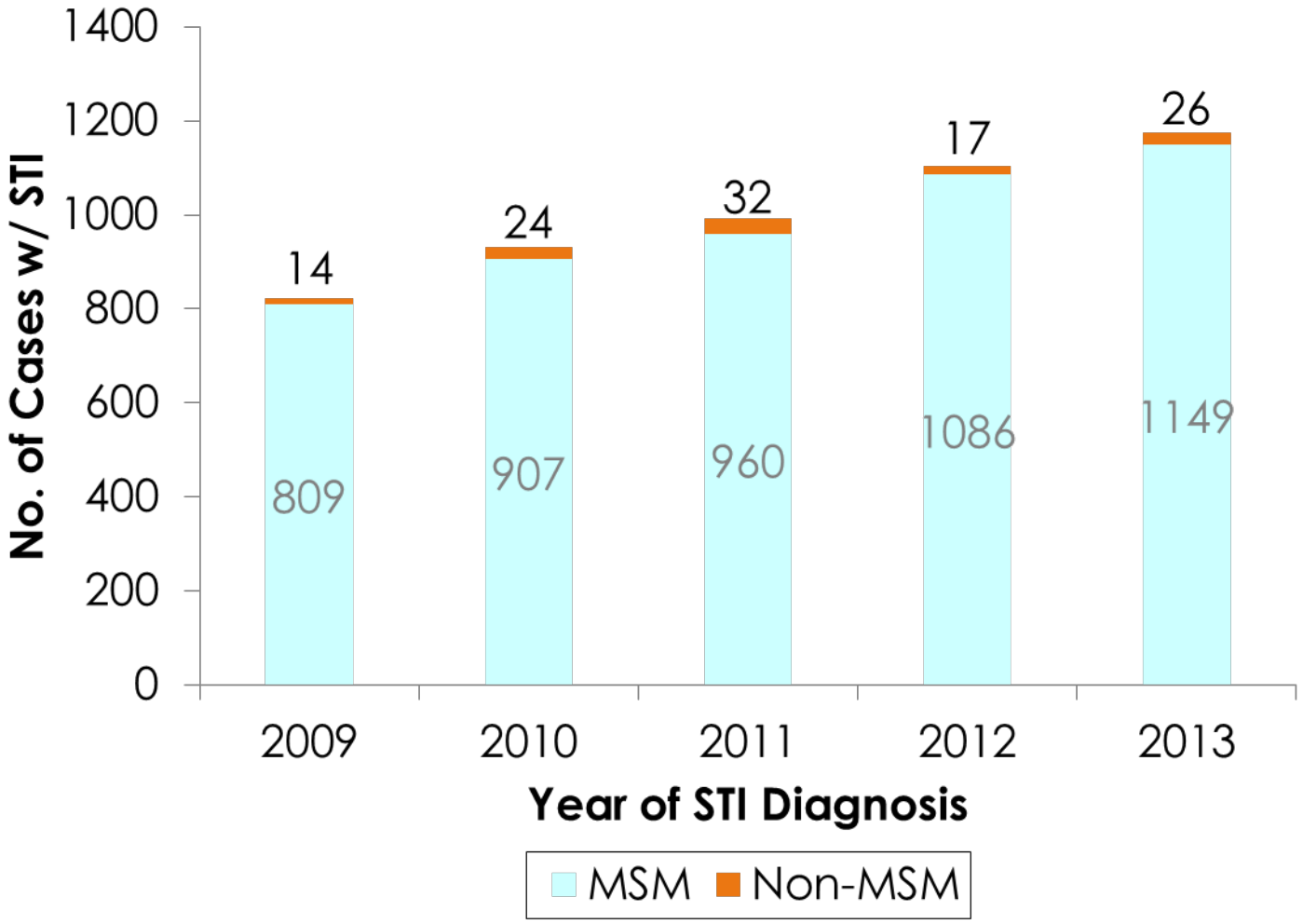
CHARACTERISTICS OF PERSONS LIVING WITH HIV SEEN IN SAN FRANCISCO JAILS, AS OF DECEMBER 2014

	PLWH (N= 15,979)	PLWH with history of jail (N= 1,094)
Gender		
Male	92%	77%
Female	6%	15%
Transgender	2%	8%
Race/Ethnicity		
White	61%	37%
African-American	13%	41%
Latino	18%	16%
API/Native American	7%	3%
Risk		
MSM	74%	21%
MSM-PWID	15%	43%
PWID	6%	29%
Other/ No Reported Risk	5%	6%

LIVING HIV CASES CO-INFECTED WITH HEPATITIS C, AS OF DECEMBER 31, 2014

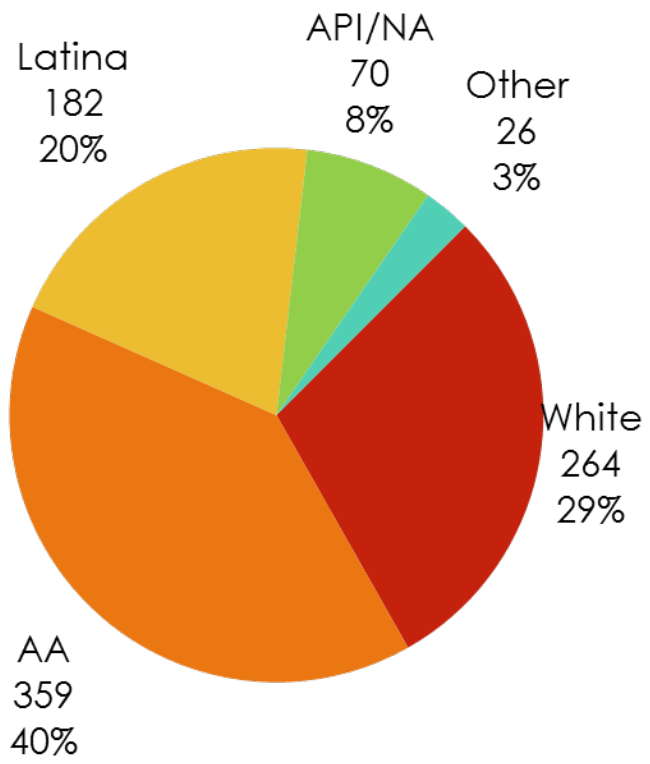


NUMBER OF HIV CASES DIAGNOSED WITH AN STI BY YEAR OF STI DIAGNOSIS, 2009-2013, SAN FRANCISCO

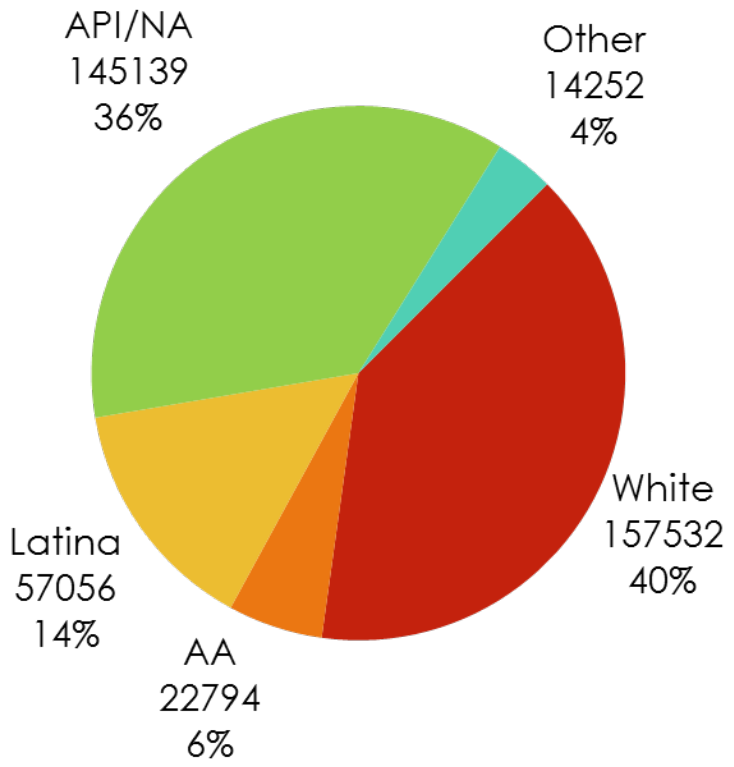


RACE/ETHNICITY OF FEMALE LIVING WITH HIV COMPARED TO THE GENERAL POPULATION OF SAN FRANCISCO, DECEMBER 31, 2014

Living Female HIV Cases
N= 901



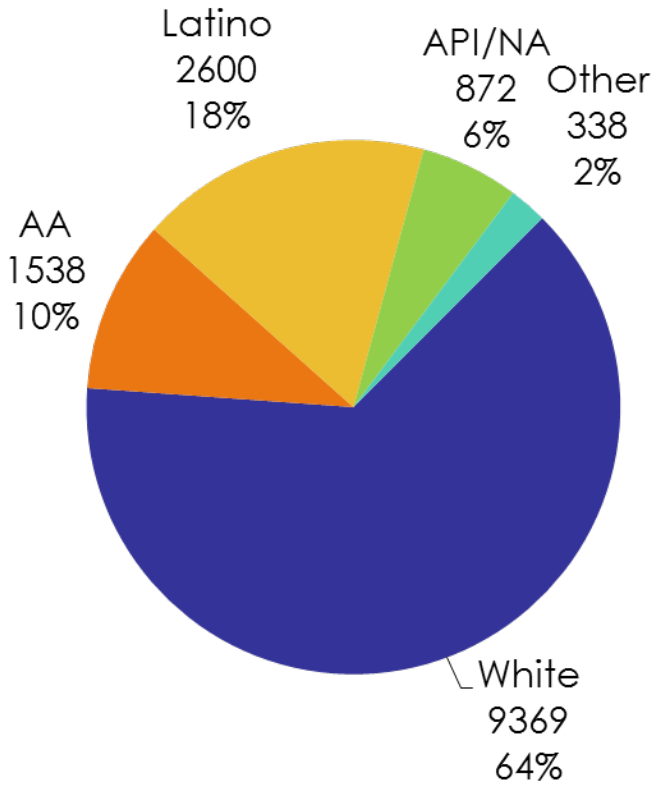
San Francisco Female Population*
N= 396,773



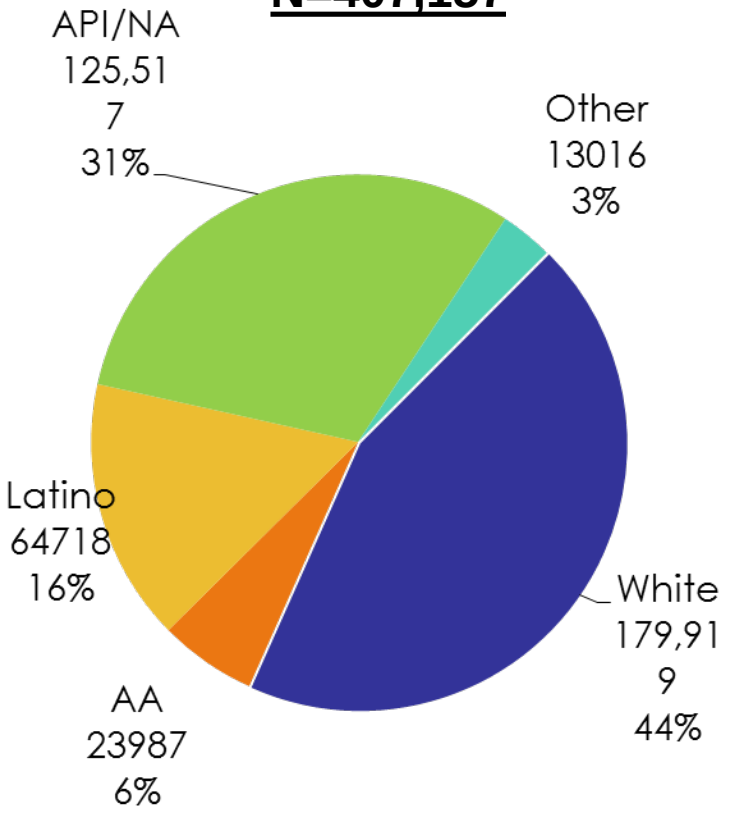
*United State 2010 Census data

RACE/ETHNICITY OF MALE LIVING WITH HIV COMPARED TO THE GENERAL POPULATION OF SAN FRANCISCO, DECEMBER 31, 2014

Male HIV Cases
N= 14,722

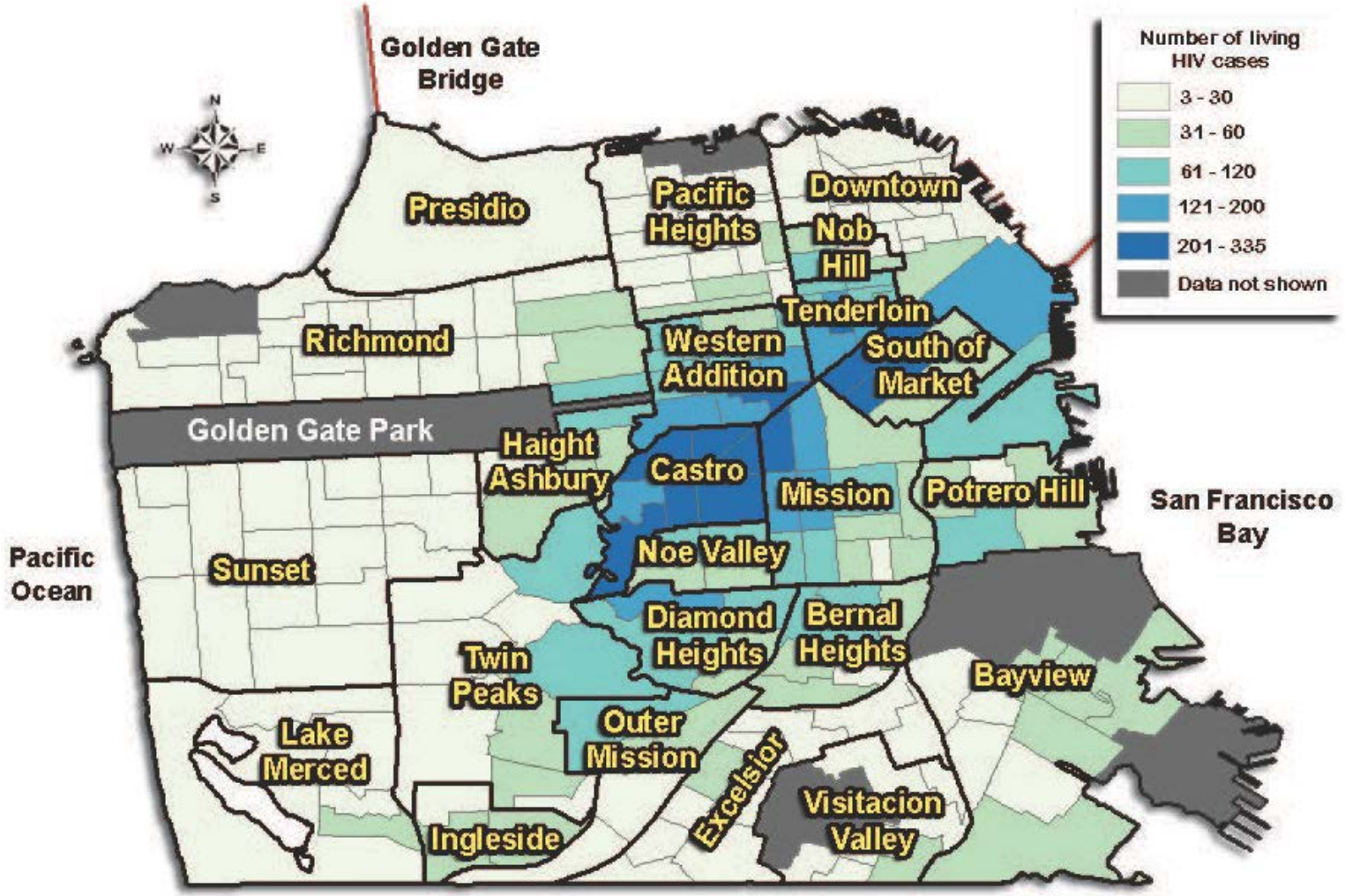


San Francisco Male Population*
N=407,157



*United State 2010 Census data

GEOGRAPHIC DISTRIBUTION OF PERSON LIVING WITH HIV, 2014



CHARACTERISTICS OF PEOPLE LIVING WITH HIV/AIDS, SAN FRANCISCO EMA AS OF 12/31/13

	San Mateo	Marin	San Francisco
Gender			
Male	83.6%	89.3%	92.0%
Female	15.7%	7.6%	5.7%
Transgender	0.7%	2.6%	2.3%
Race/Ethnicity			
White	48.4%	55.2%	61.7%
African-American	12.7%	22.3%	12.9%
Latino	26.9%	18.0%	17.4%
Asian/Pac Islander	9.6%	2.1%	5.3%
Risk			
MSM	59.8%	49.62%	73.3%
MSM-IDU	5.9%	13.3%	15.2%
IDU	10.5%	18.5%	6.3%
Heterosexual	11.9%	10.5%	3.2%
Total Known Persons Living with HIV/AIDS	**1,538 (8.4%)**	**896 (4.9%)**	**15,898 (86.7%)**

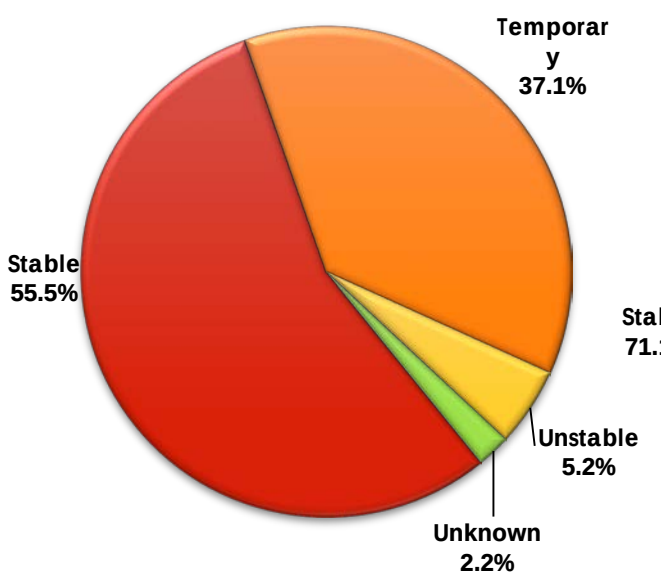
ARIES: EMA FACTOIDS

- **EMA-Wide** – The UDC is **6,503 (N = 6,503)** of which 583 or 9.0% of clients served in the EMA were "new" and 26 or 0.4% died during the reporting period. There are 158 or **2.4% shared clients** within the EMA. *Please note, with the addition of "SF Add-backs" the total EMA UDC becomes 7,347 which is an increase of 13.0% over those served with RWPA &B.*
- **Marin County** – The Marin UDC is 267 (n = 267) or **4.1%** of total EMA UDC. Thirty four(34) or 12.7% clients served in Marin were "new" and no clients died during the reporting period.
- **San Francisco County** – The San Francisco UDC is 5,845 (n = 5,845) or **89.9%** of total EMA UDC. Five hundred twelve (512) or 8.8% clients served in San Francisco were "new" and 22 or 0.4% died during the reporting period. *With "SF Add-backs" the total SF UDC becomes 6,804 which is an increase of 16.5% over those served with RWPA &B.*
- **San Mateo County** – The San Mateo UDC is 549 or **8.4%** of total EMA UDC. Fifty nine (59) or 10.7% clients served in San Mateo were "new" and 6 or 1.1% died during the reporting period.
- The UDC for each of the above groups are reflected in the following slides.

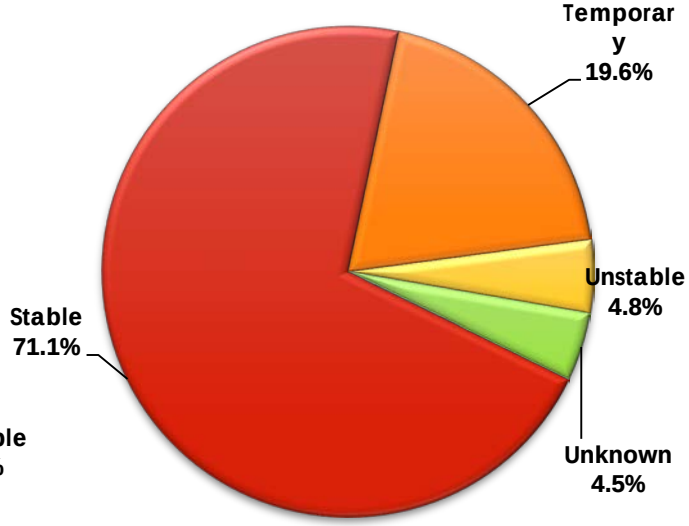
CURRENT LIVING SITUATION

Stable	Temporary	Unstable	Unknown
n=4517	n=1400	n=301	n=285
69.5%	21.5%	4.6%	4.4%

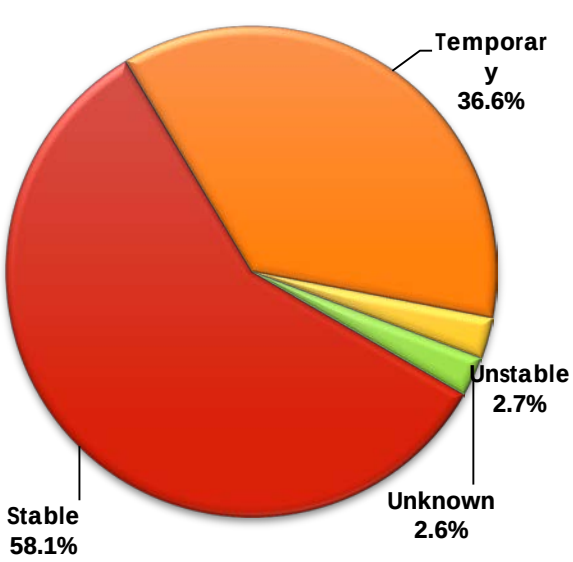
Marin



San Francisco

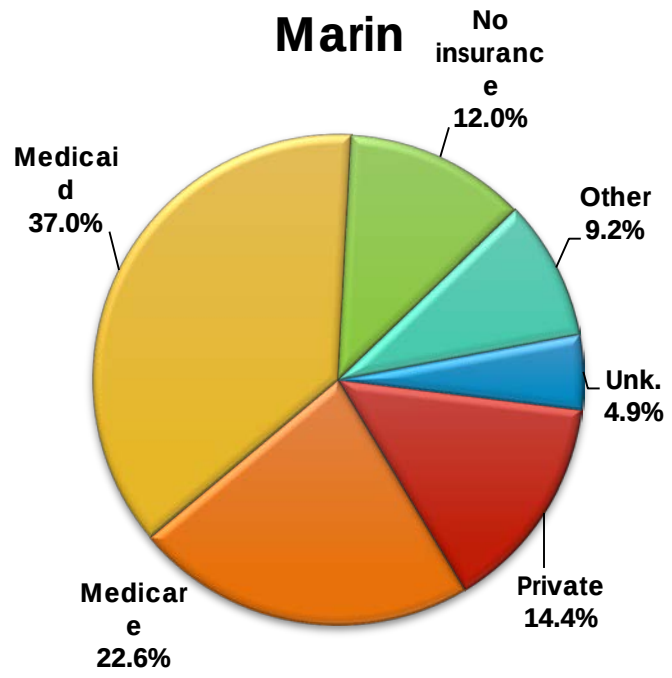


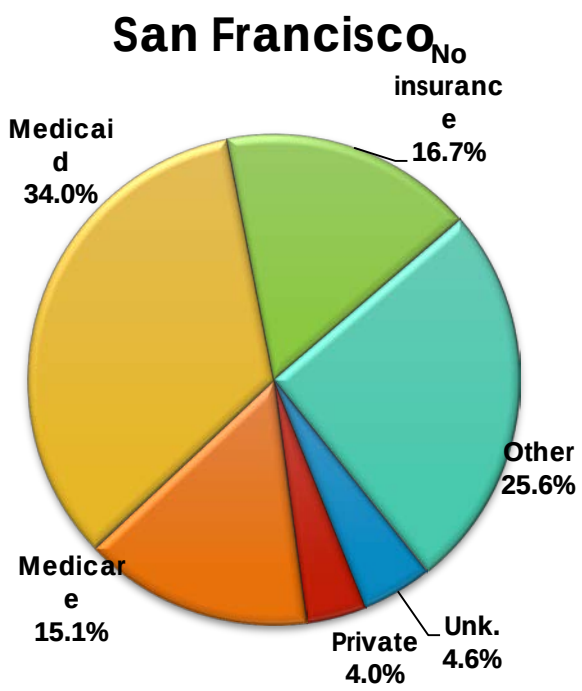
San Mateo

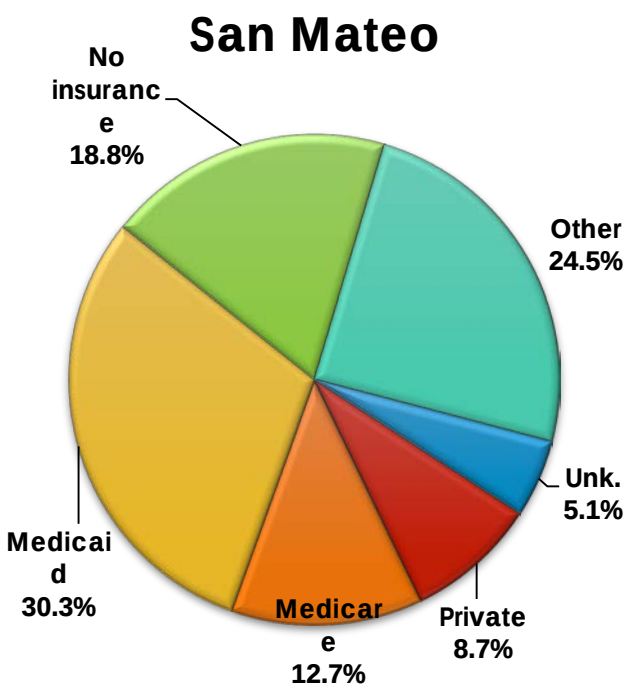


INSURANCE STATUS

Private	Medicare	Medicaid	No Insurance	Other	Unknown
n=528	n=1695	n=3786	n=1885	n=2810	n=500
8.1%	26.1%	58.2%	29.0%	43.2%	7.7%



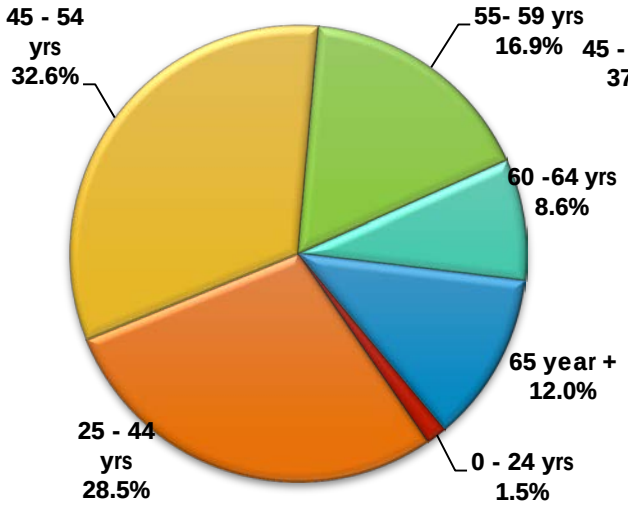




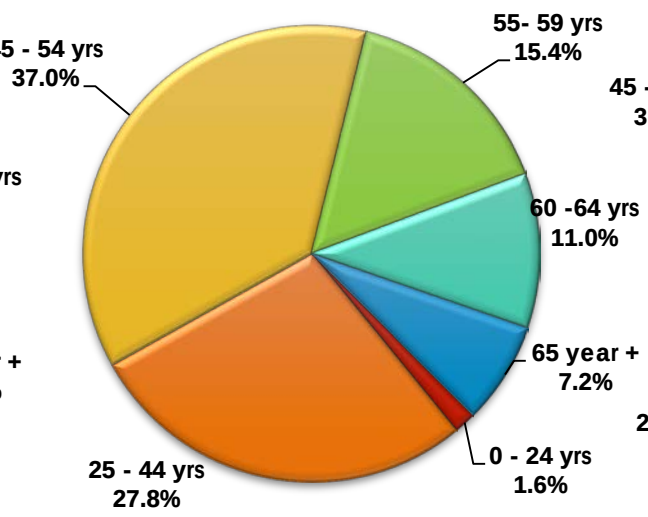
AGE

0 - 24 years	25 - 44 years	45 - 54 years	55 - 59 years	60 - 64 years	65 years +
n=105	n=1865	n=2370	n=990	n=693	n=480
1.6%	28.7%	36.4%	15.2%	10.7%	7.4%

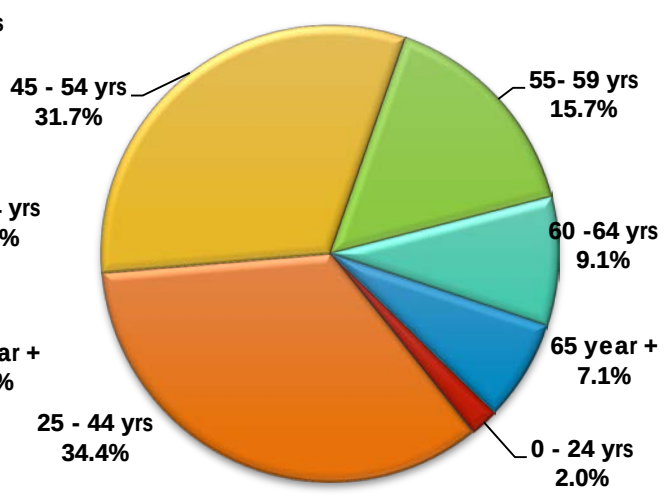
Marin



San Francisco



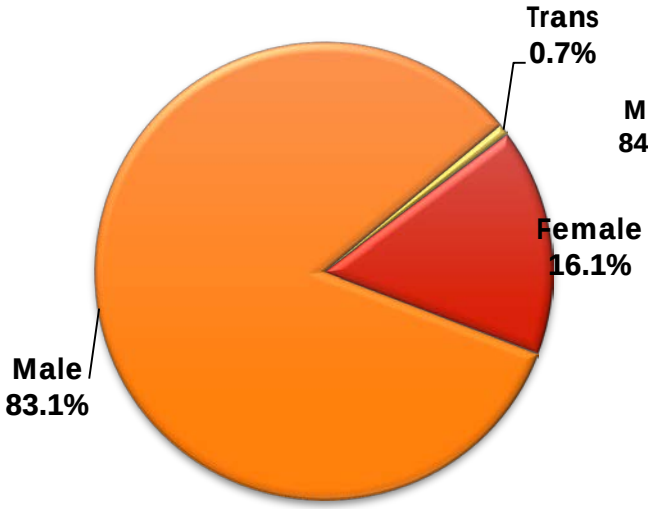
San Mateo



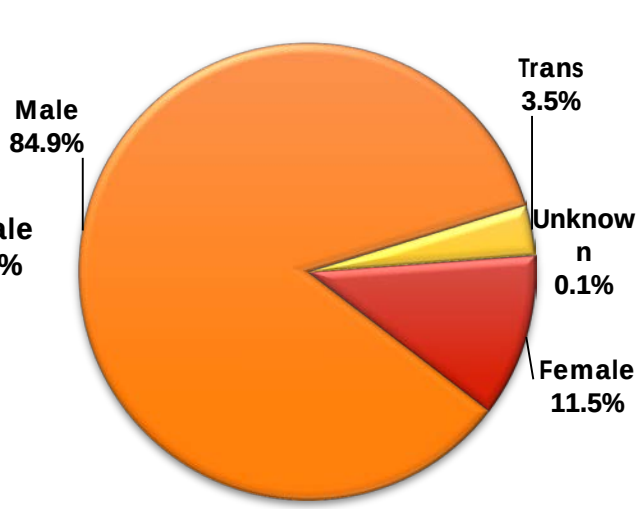
GENDER

Female	Male	Transgender	Unknown
n=782	n=5505	n=211	n=5
12.0%	84.7%	3.2%	0.1%

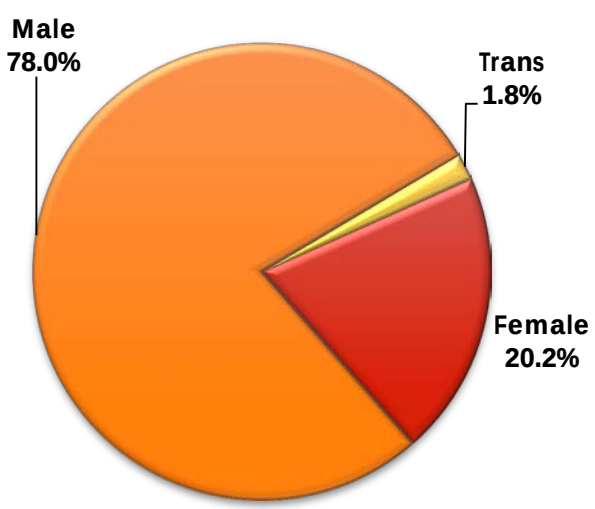
Marin



San Francisco



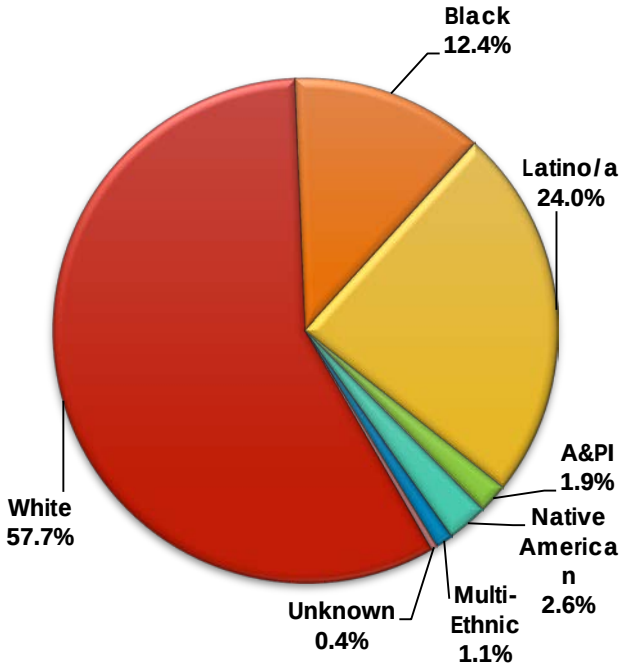
San Mateo



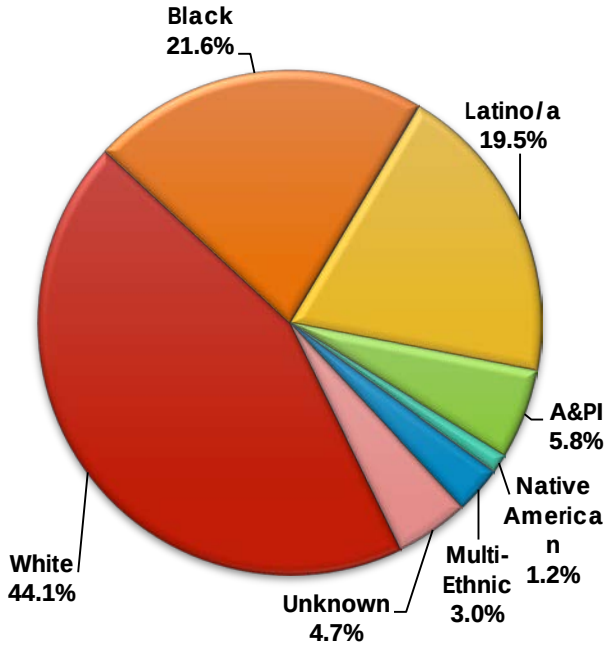
RACE

White	Black	Latino/a	Asian & Pacific Islander (A&PI)	Native American	Multi-Ethnic	Unknown
n=2835	n=1348	n=1375	n=382	n=82	n=185	n=296
43.6%	20.7%	21.1%	5.9%	1.3%	2.8%	4.6%

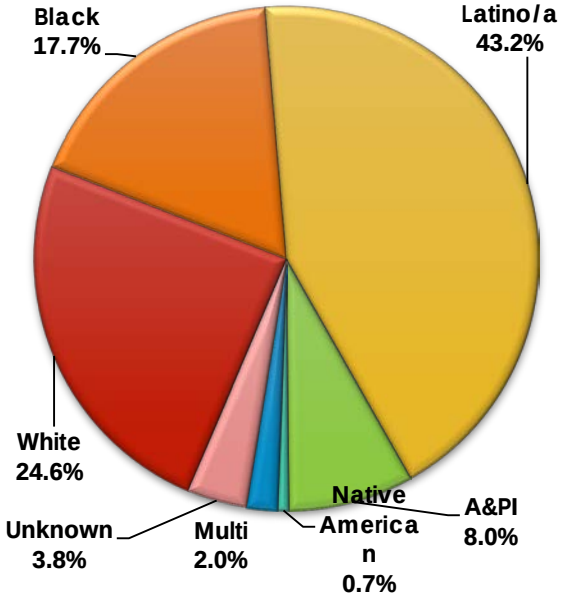
Marin



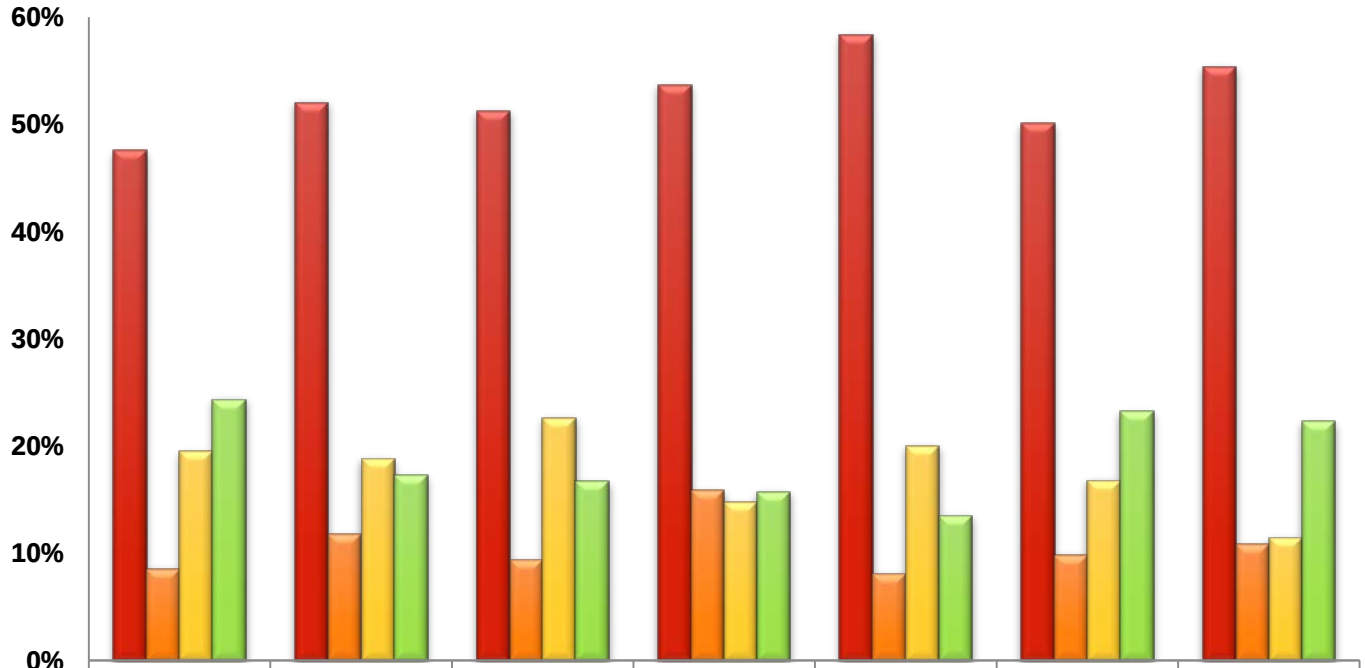
San Francisco



San Mateo



EMA RACE BY VIRAL LOAD



	Native American (n=82)	Asian & Pacific Islander (n=382)	Black (n=1348)	Latino(a) (n=1375)	Multi-Ethnic (n=185)	White (n=2835)	Unknown (n=296)
<50 (n=3359)	47.6%	52.1%	51.3%	53.7%	58.4%	50.1%	55.4%
050-199 (n=723)	8.5%	11.8%	9.4%	15.9%	8.1%	9.8%	10.8%
200 + (n=1145)	19.5%	18.8%	22.6%	14.8%	20.0%	16.9%	11.5%
Unknown (n=1276)	24.4%	17.3%	16.7%	15.7%	13.5%	23.2%	22.3%

EMA CLIENT SUMMARY

	Marin		San Francisco			San Mateo			EMA		
	Male	Female	Male	Female	Transgender	Male	Female	Transgender	Male	Female	Transgender
Age	45-54	25-44	45-54	45-54	45-54	45-54	45-54	25-44	45-54	45-54	45-54
Race	White	Latina	White	Black	Black	Latino	Latina	Latina	White	Black	Black
FPL%	**≤ 100% FPL**	**≤ 100% FPL**	**≤ 100% FPL**	**≤ 100% FPL**	**≤ 100% FPL**	**≤ 100% FPL**	**≤ 100% FPL**	101-200% FPL	**≤ 100% FPL**	**≤ 100% FPL**	**≤ 100% FPL**
Living Situation	Temporary	Stable	Stable	Stable	Stable	Stable	Stable	Temporary	Stable	Stable	Stable
Insurance Status	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid & Other	Medicaid	Medicaid	Medicaid
Sexual Orientation	Gay	Straight	Gay	Straight	Straight	Gay	Straight	Straight	Gay	Straight	Straight
HIV Exposure	MSM	Heterosexual Contact	MSM	Heterosexual Contact	Transfemale sex with men	MSM	Heterosexual Contact	Transfemale sex with men	MSM	Heterosexual Contact	Transfemale sex with men
Disease Status	AIDS	AIDS	Disabling AIDS	AIDS	Disabling AIDS	HIV+, unknown stage	HIV+, unknown stage	HIV+, unknown stage	Disabling AIDS	AIDS	Disabling AIDS

AUGUST 2015

- Service Summary Sheets Presentation
- Carry-forward Allocation motion approved:
  - $100,000 for food
  - $100,000 for dental
  - $100,000 for direct financial assistance
  - $20,000 for taxi vouchers
  - $40,000 for fast food vouchers
  - $80,000 for grocery vouchers
  - $35,000 for transportation
- Resource Allocation motion approved
- SOA, HHS, CHEP & HPPC, Public Policy Updates

RESOURCE ALLOCATION

In the event of additional funds made available due to shifts in funding from Ryan White to other funding streams, funds will be used for:

- CODB: Proportional increase across all service categories for cost of doing business
- Emergency Housing
- Navigation support: the service category Psychosocial Support will be increased to allow for increased navigation support

Any additional funding remaining after the above will be used for:

- Co-pay assistance: the service category Emergency Financial Assistance will be increased to allow for co-pay assistance
- Increase to Food Services

The Council recommends that navigation training for providers will be funded by Administrative funding through EMA Quality Management Activities.