File No. 120969

Committee Item No. 6
Board Item No. _____

# COMMITTEE/BOARD OF SUPERVISORS

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**Committee:** Budget and Finance Committee **Date** 10/10/2012

**Board of Supervisors Meeting** **Date** _____

| Cmte | Board | |
|---|---|---|
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| ☒ | ☐ | Resolution |
| ☐ | ☐ | Ordinance |
| ☐ | ☐ | Legislative Digest |
| ☐ | ☐ | Budget and Legislative Analyst Report |
| ☐ | ☐ | Legislative Analyst Report |
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| ☒ | ☐ | Department/Agency Cover Letter and/or Report |
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**OTHER** **(Use back side if additional space is needed)**

| | | |
|---|---|---|
| ☐ | ☐ | |
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| ☐ | ☐ | |

**Completed by:** Victor Young **Date** October 5, 2012
**Completed by:** Victor Young **Date** _____

FILE NO. 120969 RESOLUTION NO.

[Approval of the Ryan White Act HIV/AIDS Emergency Relief Grant Program Application - $36,118,233]

**Resolution authorizing the San Francisco Department of Public Health to submit an application to continue to receive funding for the Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A) grant from the Health Resources Services Administration, requesting $36,118,233 in HIV emergency relief program funding for the San Francisco Eligible Metropolitan Area for the period of March 1, 2013, through February 28, 2014.**

WHEREAS, Section 10.170.(b) of the San Francisco Administrative Code requires Board review of proposed annual or otherwise recurring grant applications of $5,000,000 or more prior to their submission; and

WHEREAS, San Francisco Department of Public Health (SFDPH) is currently a recipient of the "Ryan White Act HIV/AIDS Emergency Relief Grant Program" grant in the amount of approximately $36,118,233 from the Health Resources Services Administration (HRSA) for fiscal year 2012; and

WHEREAS, For this round of funding, SFDPH was instructed by HRSA to submit an application request in the amount of $36,118,233; and

WHEREAS, SFDPH uses these funds to cover a multitude of health services to HIV positive persons residing in the three counties within the San Francisco Eligible Metropolitan Areas; and

WHEREAS, Ordinance No. 265-05 requires that City Departments submit applications for approval at least 60 days prior to the grant deadline for review and approval; and

WHEREAS, HRSA released the application announcement on August 27, 2012 with a due date of October 22, 2012 allowing 56 days for the entire process; and

WHEREAS, in the interest of timeliness, SFDPH is making this request for approval by submitting its' most recent draft of the grant application, also including supporting documents as required, all of which are on file with the Clerk of the Board of Supervisors in File No. 120969, which is hereby declared to be part of the Resolution as if set forth fully herein; and, now, therefore, be it

RESOLVED, That the Board of Supervisors hereby approves SFDPH's application submission to HRSA for the "Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A)" grant for the funding period of March 1, 2013 through February 28, 2014, to be submitted no later than October 22, 2012.

RECOMMENDED:

Barbara A. Garcia, MPA
Director of Health

**City and County of San Francisco**

**Department of Public Health**

**Barbara A. Garcia, MPA**
**Director of Health**

**Ryan White HIV Emergency Relief Grant Program**
**(CARE Part A)**

Funding Criteria
The San Francisco Department of Public Health (SFDPH) is currently a recipient of the Ryan White HIV/AIDS HIV Emergency Relief Grant Program (Ryan White Programs, Part A) in the amount of $20,844,439 from the Health Resources Services Administration (HRSA). The Part A grant is awarded to the San Francisco Eligible Metropolitan Area which is comprised of the City and County of San Francisco, Marin County, and San Mateo County.

Eligible Metropolitan Areas (EMA) include communities with populations of 500,000 or more that have reported to the Centers of Disease Control and Prevention a total of more than 2,000 cases of AIDS in the most recent five calendar years.

Department's Most Recent Draft of Grant Applications Materials
Please see Attachment A for the SFDPH's most recent draft of application materials. SFDPH's most recent application was submitted to HRSA on Oct 31, 2011 for the funding period of March 1, 2012 to February 28, 2013. We have received the application guidance from HRSA for the March 1, 2013 to February 28, 2014 funding period on August 17, 2012 with an application due date of October 22, 2012.

Anticipated Funding Categories
The Part A funds are awarded to SFDPH on an annual basis to cover a multitude of health services to HIV positive persons residing in the three counties within the San Francisco EMA. Of the total award amount, only 10% can be utilized to pay administrative costs and 90% is distributed to Community Based Organizations (CBOs) to provide direct services to clients.

Please see Attachment B for an example of the FY2012-13 Planned Service Mode Allocations for the San Francisco EMA. The service modes are defined by HRSA. The San Francisco HIV Health Services Planning Council, a citizen advisory board, is responsible for determining the priorities and the allocation of funds within each HRSA service mode for the San Francisco EMA.

Comments from Relevant Citizen Advisory Board
The San Francisco HIV Health Services Planning Council, a citizen advisory board, is responsible for determining the priorities and the allocation of CARE Part A funds. A list of the members of the HIV Health Services Planning Council is included in Attachment C.

**(415) 554-9054** **25 Van Ness Ave** **San Francisco, CA 94102**

# FY2012-13 Ryan White Part A Grant Program Planned Allocations Report

San Francisco, CA

Dean Goodwin

| Allocations Categories | Marin RWPA Allocated for FY2012 | | San Mateo Allocated for FY2012 | | San Francisco Total Allocated for FY2012 | | Minority AIDS Initiative | Total FY2012 RWPA Award | |
|---|---|---|---|---|---|---|---|---|---|
| | Amount | Percent | Amount | Percent | Amount | Percent | Amount | Amount | Percent |
| **1. Core Medical Services Sub-total** Footnote 1 | **$472,500** | **75.00%** | **$1,406,597** | **85.68%** | **$13,326,089** | **84.57%** | **$717,750** | **$15,922,936** | **84.93%** |
| a. Outpatient /Ambulatory Health Services | $150,000 | 23.81% | $900,359 | 54.85% | $6,989,755 | 44.36% | $530,555 | $8,570,669 | 45.72% |
| b. AIDS Drug Assistance Program (ADAP) Treatments | $0 | 0.00% | $0 | 0.00% | $0 | 0.00% | $0 | $0 | 0.00% |
| c. AIDS Pharmaceutical Assistance (local) | $10,000 | 1.59% | $0 | 0.00% | $0 | 0.00% | $0 | $10,000 | 0.05% |
| d. Oral Health Care | $21,000 | 3.33% | $180,000 | 10.96% | $743,149 | 4.72% | $0 | $944,149 | 5.04% |
| e. Early Intervention Services | $0 | 0.00% | $0 | 0.00% | $166,586 | 1.06% | $0 | $166,586 | 0.89% |
| f. Health Insurance Premium & Cost Sharing Assistance | $0 | 0.00% | $0 | 0.00% | $0 | 0.00% | $0 | $0 | 0.00% |
| g. Home Health Care | $45,500 | 7.22% | $0 | 0.00% | $554,145 | 3.52% | $0 | $599,645 | 3.20% |
| h. Home and Community-based Health Services | $0 | 0.00% | $0 | 0.00% | $481,434 | 3.06% | $0 | $481,434 | 2.57% |
| i. Hospice Services | $0 | 0.00% | $0 | 0.00% | $1,077,998 | 6.84% | $0 | $1,077,998 | 5.75% |
| j. Mental Health Services | $92,000 | 14.60% | $101,260 | 6.17% | $1,837,951 | 11.66% | $0 | $2,031,211 | 10.83% |
| k. Medical Nutrition Therapy | $0 | 0.00% | $0 | 0.00% | $0 | 0.00% | $0 | $0 | 0.00% |
| l. Medical Case Management (including Treatment Adherence) | $148,000 | 23.49% | $154,699 | 9.42% | $1,475,071 | 9.36% | $187,195 | $1,964,965 | 10.48% |
| m. Substance Abuse Services - Outpatient | $6,000 | 0.95% | $70,279 | 4.28% | $0 | 0.00% | $0 | $76,279 | 0.41% |
| **2. Support Services Subtotal** | **$157,500** | **25.00%** | **$235,032** | **14.32%** | **$2,431,963** | **15.43%** | **$0** | **$2,824,495** | **15.07%** |
| a. Case Management (non-Medical) | $108,000 | 17.14% | $0 | 0.00% | $339,230 | 2.15% | $0 | $447,230 | 2.39% |
| b. Child Care Services | $0 | 0.00% | $0 | 0.00% | $0 | 0.00% | $0 | $0 | 0.00% |
| c. Emergency Financial Assistance | $28,500 | 4.52% | $62,495 | 3.81% | $633,239 | 4.02% | $0 | $724,234 | 3.86% |
| d. Food Bank/Home-Delivered Meals | $10,000 | 1.59% | $110,000 | 6.70% | $274,456 | 1.74% | $0 | $394,456 | 2.10% |
| e. Health Education/Risk Reduction | $0 | 0.00% | $0 | 0.00% | $0 | 0.00% | $0 | $0 | 0.00% |
| f. Housing Services | $0 | 0.00% | $11,129 | 0.68% | $701,129 | 4.45% | $0 | $712,258 | 3.80% |
| g. Legal Services | $0 | 0.00% | $0 | 0.00% | $183,330 | 1.16% | $0 | $183,330 | 0.98% |
| h. Linguistics Services | $0 | 0.00% | $0 | 0.00% | $0 | 0.00% | $0 | $0 | 0.00% |
| i. Medical Transportation Services | $9,000 | 1.43% | $10,908 | 0.66% | $0 | 0.00% | $0 | $19,908 | 0.11% |
| j. Outreach Services | $0 | 0.00% | $0 | 0.00% | $172,417 | 1.09% | $0 | $172,417 | 0.92% |
| k. Psychosocial Support Services | $0 | 0.00% | $0 | 0.00% | $128,162 | 0.81% | $0 | $128,162 | 0.68% |
| l. Referral for Health Care/Supportive Services | $0 | 0.00% | $0 | 0.00% | $0 | 0.00% | $0 | $0 | 0.00% |
| m. Rehabilitation Services | $0 | 0.00% | $0 | 0.00% | $0 | 0.00% | $0 | $0 | 0.00% |
| n. Respite Care | $0 | 0.00% | $0 | 0.00% | $0 | 0.00% | $0 | $0 | 0.00% |
| o. Substance Abuse Services - residential | $2,000 | 0.32% | $40,500 | 2.47% | $0 | 0.00% | $0 | $42,500 | 0.23% |
| p. Treatment Adherence Counseling | $0 | 0.00% | $0 | 0.00% | $0 | 0.00% | 0% | $0 | 0.00% |
| **3. Total Service Dollars** | **$630,000** | **99.21%** | **$1,641,629** | **100.00%** | **$15,758,052** | **88.68%** | **$717,750** | **$18,747,431** | **89.94%** |
| **4. Clinical Quality Management Activities** Footnote 2 | **$0** | **0.00%** | **$0** | **0.00%** | **$350,000** | **1.97%** | **$0** | **$350,000** | **1.68%** |
| **5. Grantee Administration** Footnote 3 | **$5,033** | **0.79%** | **$0** | **0.00%** | **$1,662,225** | **9.35%** | **$79,750** | **$1,747,008** | **8.38%** |
| **6. Total Allocations** Footnote 4 | **$635,033** | **100.00%** | **$1,641,629** | **100.00%** | **$17,770,277** | **100.00%** | **$797,500** | **$20,844,439** | **100.00%** |

(1) At least 75% of the grant award must be spent on core medical services.

(3) May not exceed 10% of FY2010 award.

(4) Must equal the total FY2010 award.

# Council Membership - Roster

As of: July 18, 2012

| | Last | First | Email | Company | Term Ends |
|---|---|---|---|---|---|
| 1. | Agtane | Mark | inquisitivechef@gmail.com | | 8/24/14 |
| 2. | Andrews | John L. | smileyandrews@comcast.net | | 10/10/12 |
| 3. | Antonetty | Margot | margot.antonetty@sfdph.org | CCSF Department of Public Health | 1/31/14 |
| 4. | Cooper | Billie J. | msbilliecooper@yahoo.com | | 10/02/12 |
| 5. | DiCrocco | Brian C | brian_dicrocco@yahoo.com | | 1/30/14 |
| 6. | Emerson | Cicily | cemerson@co.marin.ca.us | Marin Department of Health and Human Services | 6/27/13 |
| 7. | Flores | Wade | walksinwater@netzero.net | | 10/30/13 |
| 8. | Gatewood | Liz | gatewood0221@yahoo.com | | 3/31/14 |
| 9. | Geltmaker | Matt | mgeltmaker@co.sanmateo.ca.us | San Mateo County Health Department | 6/13/13 |
| 10. | Haith | Justin | justinhaith@gmail.com | | 9/25/14 |
| 11. | Hernandez | Ronaldo G. | rhonhern@yahoo.com | | 5/20/14 |
| 12. | Hicks | Mary Lawrence | mlhicks@php.ucsf.edu | AETC/ UCSF Positive Health Program | 9/02/12 |
| 13. | Hornby | Kenneth | kennethfunny1@comcast.net | | 6/13/13 |
| 14. | Hudson | Carol | chudson39@yahoo.com | | 9/30/12 |
| 15. | Jewell | Ronald Lee | rljinsf@gmail.com | | 9/25/14 |
| 16. | Matillano | Rachel | rachel.matillano@gmail.com | | 6/27/13 |
| 17. | Miller | Matthew Simon | matthew.simon.miller@gmail.com | | 3/28/13 |
| 18. | Newell | Catherine | cathynewell4@gmail.com | | 4/30/14 |
| 19. | Ortega | Gabriel | No email | | 5/20/14 |
| 20. | Pearce | Ken | kwpsf@aol.com | | 8/31/13 |
| 21. | Penagos | Maritza | maritza.penagos@bcef.org | Breast Cancer Emergency Fund | 12/01/12 |
| 22. | Scarce | Michael | scarce@mac.com | | 1/24/14 |
| 23. | Scherich | Stacia Anne | staciascherich@hotmail.com | | 6/13/13 |
| 24. | Simmons | George | gsimmons@cccyo.org | Catholic Charities CYO | 5/24/14 |
| 25. | Siron | Charles | robles94102@aol.com | | 2/28/14 |
| 26. | Smith | Gwen | gwen.smith@sfdph.org | SFDPH-Southeast Health Center | 1/31/14 |
| 27. | Smithwick | Michael Lee | baydesert@me.com | Maitri AIDS Hospice | 3/25/14 |
| 28. | Soto | Donald | dsoto@lssnorcal.org | Lutheran Social Services of N. California | 8/31/13 |
| 29. | Supanich | Chip | chipsup@att.net | | 1/24/13 |
| 30. | Sutter | Eric | esutter@shanti.org | Shanti Project | 3/31/14 |
| 31. | Tannenbaum | Lara | ltannenbaum@larkinstreetyouth.org | Larkin Street Youth Services | 1/31/14 |
| 32. | Thomas | Laura | lgthomas@gmail.com | | 2/28/14 |
| 33. | Wayne | Channing | cwayne@waynecorgroup.com | | 4/27/14 |

***There is one additional Council Member, not listed because the PlanningCouncil is waiting for Mayoral Approval before term end date can be determined.**

OMB Number: 4040-0004
Expiration Date: 03/31/2012

## Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

**State Use Only:**

6. Date Received by State:

7. State Application Identifier:

**8. APPLICANT INFORMATION:**

* a. Legal Name: San Francisco Department of Public Health

* b. Employer/Taxpayer Identification Number (EIN/TIN): 94-60000417

* c. Organizational DUNS: 1037173360000

**d. Address:**

* Street1: 1380 Howard Street
Street2:
* City: San Francisco
County/Parish:
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 94103-2638

**e. Organizational Unit:**

Department Name:

Division Name:

**f. Name and contact information of person to be contacted on matters involving this application:**

Prefix:
* First Name: Bill
Middle Name:
* Last Name: Blum
Suffix:

Title:

Organizational Affiliation:

* Telephone Number: 415-554-9000
Fax Number:

* Email: Bill.Blum@sfdph.or

## Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Health Resources & Services Administration

**11. Catalog of Federal Domestic Assistance Number:**

93.914

CFDA Title:

HIV Emergency Relief Project Grants

*** 12. Funding Opportunity Number:**

HRSA-12-128

* Title:

Ryan White Part A HIV Emergency Relief Grant Program

**13. Competition Identification Number:**

5085

Title:

**14. Areas Affected by Project (Cities, Counties, States, etc.):**

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

HIV Emergency Relief Grant Program (HIV Care Program Part A)

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

## Application for Federal Assistance SF-424

**16. Congressional Districts Of:**

* a. Applicant CA-008 b. Program/Project CA-008

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

**17. Proposed Project:**

* a. Start Date: 03/01/2012 * b. End Date: 02/28/2013

**18. Estimated Funding ($):**

| | |
|---|---|
| * a. Federal | 36,118,233.00 |
| * b. Applicant | 0.00 |
| * c. State | 0.00 |
| * d. Local | 0.00 |
| * e. Other | 0.00 |
| * f. Program Income | 0.00 |
| * g. TOTAL | 36,118,233.00 |

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

- [ ] a. This application was made available to the State under the Executive Order 12372 Process for review on .
- [x] b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- [ ] c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

- [ ] Yes
- [x] No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

**21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

- [x] ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

**Authorized Representative:**

Prefix: * First Name: Barbara

Middle Name:

* Last Name: Garcia

Suffix:

* Title: Director of Health

* Telephone Number: 415-554-2526 Fax Number: 415-554-2710

* Email: Barbara.Garcia@sfdph.org

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

San Francisco EMA
Ryan White Part A Budget Justification
March 1, 2012 - February 28,2013

**San Francisco EMA CARE Part A Budget Justification (March 1, 2012 - February 28,2013)**

**A & B PERSONAL AND MANDATORY FRINGE BENEFITS**

| | FTE | | COST |
|---|---|---|---|
| **HEALTH SERVICE UNIT** | | | |
| 1 Interim Director of HIV Services (B. Blum) - Charged with primary oversight for the administration of services and day to day operations of HIV Health Services and the Ryan wite Part A grant. | 0.40 | $ | 43,555 |
| 2 Director of Contractual Development & Technical Assistance (M. Long) - Charged with oversight of contract development, modications and renewals of all Ryan White Part A grant. | 0.50 | $ | 67,717 |
| 3 Director of Contract Compliance ( D. Einhorn) - Charged with oversight of contract compliance, contractor monitoring and reporting, auditing. | 0.50 | $ | 52,774 |
| 4 Health Program Coordinator III (D. Macias, F. Austin, J. Cecere, M. Herring, H. Jones) - Charged with programmatic oversight and monitoring of programs. | 2.95 | $ | 280,799 |
| 5 Program Support Analyst (Vacant) - Manages and collect CADR data; Coordinate all eligibility issues/systems. | 0.50 | $ | 46,358 |
| 6 Sr Administrative Analyst (D. Goodwin) - Coordinates development of contracts and monitoring process; Analyzes service cost/utilization. | 0.80 | $ | 76,523 |
| 7 Administrative Analyst (C. Gortner) - Assists in preparation of Part A application. Quality Mgmt training and coordinator of Contract Monitoring Process. | 0.50 | $ | 77,402 |
| 8 Clerk (N.Davis) - Responsible for providing receptionist support of CARE funded HIV Health Svcs Staff. | 0.25 | $ | 12,409 |
| 9 IS Operator (Q. Wang) - Responsible for maintaining data integrity and security. | 0.97 | $ | 53,340 |
| **BUSINESS & FINANCE SERVICES** | | | |
| 10 Administrative Analyst (D. Cheung) - Analysis of contractor performance and financial information. | 0.50 | $ | 38,701 |
| 11 Sr. Administrative Analyst (S. Shaikh) - Management of grant compliance and administration. | 0.50 | $ | 47,827 |
| 12 Administrative Analyst (A. Salcedo) - Fiscal processing of operating expenses, invoices & professional agreements | 0.25 | $ | 19,351 |
| **CONTRACT MANAGEMENT** | | | |
| 13 Principal Admin Analyst (I. Carmona) - Supervises Contract Staff. Assures contract development compliance. | 0.25 | $ | 27,677 |
| 14 Sr Admin Analyst (N. Foote, K. Smith, K. Ly, W. Gaitan) - Processes contracts. Compliance with government regulations | 1.15 | $ | 110,002 |
| 15 Clerk ( Vacant) - Clerical support for contract preparation, assembly and processing | 0.50 | $ | 24,817 |
| **PERSONNEL SERVICES** | | | |
| 16 Senior Business Analyst (R. Pera) - Processes grantee payroll and benefits. Assists in recruitment hiring process. | 0.20 | $ | 20,982 |
| **ACCOUNTING SERVICES** | | | |
| 17 Senior Accountant (R. Cadardang) - Processes J/E's, claim reimbursement, performs expediture analysis/reconciliation. | 0.50 | $ | 38,038 |
| 18 Principal Accountant (O. David) - Oversees accounting activities, prepares financial reports and reconciliation. | 0.50 | $ | 45,981 |

**COLA (2%) & STEP INCREASES (5%):** Average rates of Labor Union Agreements per employee classifications

**FRINGE BENEFIT @ 36.0% OF BASE SALARY:** Social Security Tax, Retirement, Medicare, Health Insurance, Dependent Coverage, Dental Insurance, Unemployment Insurance, Long Term Disability. $ 392,001

**C. TRAVEL**

1 Travel: $0.52/mile for program monitoring and to provide contractor technical assistance for program staff. $ 377

Out of Jurisdiction Travel: a) Staff Director 3 Trips to Washington D.C. Estimated at $1,533/each = $5,049 $ 5,499

b) State Travel @ $150 Trip x4 trips for Coordinated Statement of Need & Conference on Evaluation of CARE funded programs

**D. EQUIPMENT** $ -

**E SUPPLIES:** Office supplies and computer upgrade of software for staff funded by Ryan White Part A $ 18,142

**F OTHER EXPENSES:** Telephone $2,800, Rent $22,000, Courier $402, Training $2,900, Meeting $800, Storage $300 $ 29,202

**G CONTRACTUAL SERVICES:** Contract/MOU Services

| | | |
|---|---|---|
| **HIV Services - Contract/MOU Services** | $ | 33,109,805 |
| **MAI Services - Contract/MOU Services** | $ | 710,140 |
| **Planning Council** | $ | 418,815 |
| **Quality Management** | $ | 350,000 |
| **TOTAL BUDGET** | $ | 36,118,233 |

# PREPARING FOR CHANGE:
# SAN FRANCISCO EMA FY 2012 RYAN WHITE PART A
# COMPETING CONTINUATION APPLICATION NARRATIVE
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# PREPARING FOR CHANGE: SAN FRANCISCO EMA FY 2012 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**

## 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 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 **one-third (33%)** of the city's total population. 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, not including as many as **75,000** permanent and semi-permanent undocumented residents.

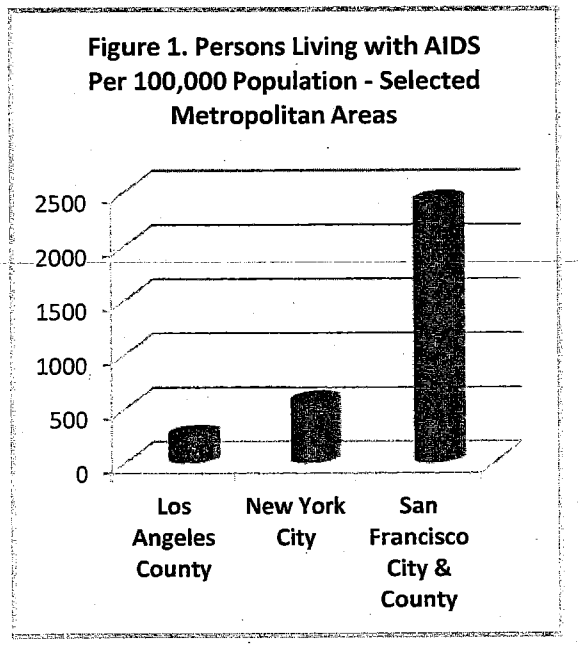
## 1.a) HIV/AIDS Epidemiology

### 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 December 31, 2010, a total of **32,742** 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=**159,329**).[3] Over **21,626** persons have already died of AIDS in the EMA. As of December 31, 2010, a total of **11,464** persons were living with AIDS in the EMA's three counties while approximately the same number were believed to be living with HIV, for an estimated total of at least **22,928** 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 **1,290.9** cases per 100,000 persons, meaning that approximately **1 in every 78 residents of the San Francisco EMA is now living with HIV.** A total of **1,289** new cases of AIDS were diagnosed in the EMA over the three-year period between January 1, 2008 and December 31, 2010 alone, representing **11.2%** 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 AIDS is both the fourth leading cause of death among all male residents age 25-54 and the leading cause of death among Latinos in that age group.**[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 December 31, 2010, a cumulative total of **28,761** 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 2009 (n=**1,089,714**) and nearly **20%** of all AIDS cases diagnosed in California (n=**159,329**), despite the fact that San Francisco County contains only **2%** of the state's population.[7] As of the end of 2010, an estimated **19,390** San Franciscans were living with AIDS or HIV, representing **84.6 %** of all persons living with HIV/AIDS in the EMA, for a staggering



citywide prevalence of **2,408** cases of HIV per 100,000. **This means that more than 1 in every 41 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 2010, the incidence of persons living with AIDS per 100,000 in San Francisco County was over **nearly ten times** that of Los Angeles County (**248.1** per 100,000) and **more than four times** that of New York City (**561.9** 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 (**62.2%**), while **13.6%** of cases are among African Americans; **16.8%** are among Latinos; and **5.2%** are among Asian / Pacific Islanders. A total of **4,429** persons of color were living with AIDS in the San Francisco EMA as of December 31, 2009, representing **38.6%** of all PLWA, while another **4,242** persons of color were estimated to be living with HIV as of the same date (**37.0%** of all PLWHA), for a total of **9,101** 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 38.6% of all people living with AIDS as of December 31, 2009 were persons of color, **nearly half** (**49.7%**) of new AIDS cases diagnosed between January 1, 2008 and December 31, 2010 were among persons of color (n=**641**). Latinos grew from **15.5%** to **16.8%** of all PLWHA living in the EMA between 12/31/08 and 12/31/10, while Asian / Pacific Islanders increased from **4.8%** to **5.2%** of cases over the same period. Additionally, among transgender persons, people of color make up **79.6%** of all PLWHA, including a population that is **35.4%** African American, **30.7%** Latino, and **9.7%** 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 on MSM has declined over time as other populations such as injection drug users and heterosexuals 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 not been as high. Through December 31, 2010, fully **86.0%** of the population of persons living with HIV/AIDS in our region were MSM (**19,717**), including **16,541** men infected with HIV through MSM contact only (**72.0%** of all PLWHA) and **3,176** MSM who also injected drugs (**13.9%** of all PLWHA). This represents an increase from the end of 2008, when the percentage stood at **82.3%**. By comparison, only **33.0%** of PLWHA in New York City as of December 31, 2009 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 and the large number of long-term HIV survivors in the region. Other significant local transmission categories include heterosexual injection drug users (**7.3%** of PLWHA) and non-IDU heterosexuals (**3.6%**). There are signs that this latter population may be increasingly, however, with **6.9%** of new AIDS cases between 2008 and 2010 occurring among non-drug-using heterosexuals (n=**89**).

***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 (**91.6%**) are men. **6.2%** of all PLWHA in the region are women, **71.3%** of whom are women of color. Among African Americans living with HIV/AIDS, fully **18.1%** are women. **The San Francisco EMA has by far the lowest percentage of women, infants, children, and youth (WICY) living with HIV/AIDS through 2008 of any EMA or TGA in the nation, with WICY**

**populations making up only 7.95% of local PLWHA.** By comparison, the next highest EMA - December, CO - has a WICY percentage of 11.49%. The proportion of women with AIDS in the EMA may also be increasing, with women making up **9.2%** of new AIDS cases diagnosed between January 1, 2008 and December 31, 2010. Because of their high representation within the San Francisco population, **transgender persons** also make up a significant percentage of PLWHA, with at least **504** transgender individuals - the vast majority of them male-to-female transgender – estimated to be living with HIV or AIDS in the EMA as of December 31, 2010, a figure representing **2.2%** of the region's PLWHA caseload.[10]

***Current Age:*** **An increasingly high proportion of persons living with HIV and AIDS in our region are age 50 and above.** This is attributable both to the long history of the HIV/AIDS epidemic in our EMA, resulting in a large proportion of long-term survivors, and the region's hard-fought success in bringing persons with HIV into care. Among the EMA's combined PLWHA population as of December 31, 2010, **more than two out of every five people living with HIV/AIDS (42.7%)** are age 50 or older, including **413** PLWHA age 70 and older. **Persons 50 and older now make up the majority of persons living with AIDS in our EMA, constituting 52.7% of this population as of the end of 2010.** Between December 2007 and December 2010 alone, the number of persons 50 and over living with AIDS increased by **10.9%** within the EMA, while the overall number of PLWA increased by only **2%**. This growing aging population creates dramatic challenges for the 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 are between the ages of 40 and 49, who make up **37.3%** of the combined PLWHA population, and **34.4%** of new AIDS diagnoses between January 1, 2008 and December 31, 2010. A total of **316** young people between the ages of 13-24 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 **5.2%** of all new AIDS cases diagnosed between January 1, 2008 and December 31, 2010, pointing to a growing HIV incidence within this population. Only **13** children age 12 and under are estimated to be living with HIV or AIDS in the EMA, and only **3** new AIDS cases were diagnosed among this group between January 1, 2008 and December 31, 2010.

The chart below summarizes the total number of new AIDS cases reported within the past three calendar years from 2008 through 2010.

| Number of new AIDS Cases Reported in San Francisco EMA - 2008 - 2010 | | |
|---|---|---|
| **CY 2008** | **CY 2009** | **CY 2010** |
| **525** | **397** | **367** |

**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 **13.6%** 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 **62.2%** 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 **5.2%** of PLWHA cases while Latinos constitute **16.8%** of PLWHA but make up **19.3%** of EMA residents. However, new HIV cases will soon create a disproportionate impact among Latinos as well, as **20.7%** of newly diagnosed AIDS cases occurred among Latinos between January 1, 2008 and December 31, 2010.

**Homeless** and **formerly incarcerated individuals** are significantly over-represented among persons living with HIV and AIDS in our region. While the combined annual EMA-Wide Homelessness Rate is estimated at **1,571** per 100,000, including an estimated **13,500** chronic homeless and another **13,140** individuals who become homeless at some point each year,[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 California Department of Corrections, an average total of **5,134** persons are held in jail settings **each day** in the San Francisco EMA,[13] while a minimum of **65,000** 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 incarcerated persons - a total of at least **646** individuals incarcerated in the San Francisco County jail were HIV-positive and receiving Ryan White services between July 1, 2008 and June 30, 2011 representing **7.9%** of the city's total Ryan White caseload of **8,171** clients as of February 28, 2011, for a three-year incarceration rate of **7,906** 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**. Approximately **63,577** gay-identified MSM live in the San Francisco EMA,[15] and an estimated **19,717** of them were HIV infected as of December 31, 2010. **This means that a startling 31.0% of all gay-identified MSM in the San Francisco EMA may already be HIV-infected, setting the stage for a continuing health crisis that will impact the future of our region for decades to come.** By contrast, less than **0.4%** of heterosexual men are estimated to be HIV-infected in the San Francisco EMA.

**Underrepresented Populations in the Ryan White System:** Compared to their proportion of HIV/AIDS cases, **women, persons of color, heterosexuals,** and **transgender people** are **over-represented** in the local Ryan White-funded system, while **whites** and **men** are **underrepresented** due to higher average incomes and higher rates of private insurance. For the same reason, MSM are underrepresented among Ryan White clients, even though they make up the majority of Ryan White clients as of February 28, 2011 . 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, Part D programs operated by Larkin Street Youth Services and the Family Service Network primarily serve young people and women, while Part C programs operated by the San Francisco Clinic Consortium and Tenderloin Health serve the full spectrum of clients, including the homeless, persons of color, women, and gay/bisexual men. Fully **20.8%** of Ryan White clients in the San Francisco EMA are African American as compared to **13.6%** of all persons with HIV/AIDS in the EMA, while 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 **6.2%** of the total PLWHA population, make up **11.0%** of Ryan White and

**21.7%** of Centers of Excellence clients. Transgendered people make up an estimated **3.0%** of persons served through the Ryan White system and **5.4%** of persons served through Centers of Excellence while making up **2.2%** 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 2008 Unmet Need Framework (see Section 1.g below), a total of **2,898** HIV-aware individuals in the San Francisco EMA are currently **not** receiving HIV primary care, representing **14%** of the region's total estimated HIV-aware population. This is a significant reduction from last year's estimate, in which **3,654 (18%)** 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.** Between March 1, 2010 and February 28, 2011, at least **8,171** individuals were receiving Ryan White services in the EMA, representing an impressive **44.8%** of the region's combined PLWHA population in care, and **35.6%** of the PLWHA population.

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

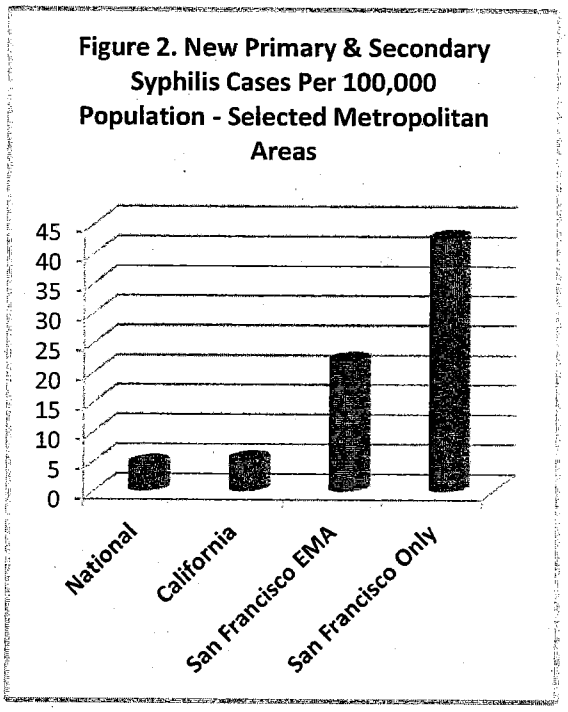
## 1.b) Impact of Co-Morbidities and Medicaid Funding on the Cost and Complexity of Providing Care

### 1.b.i) Quantitative Evidence on Co-Morbidities - See Table in Attachment 4

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

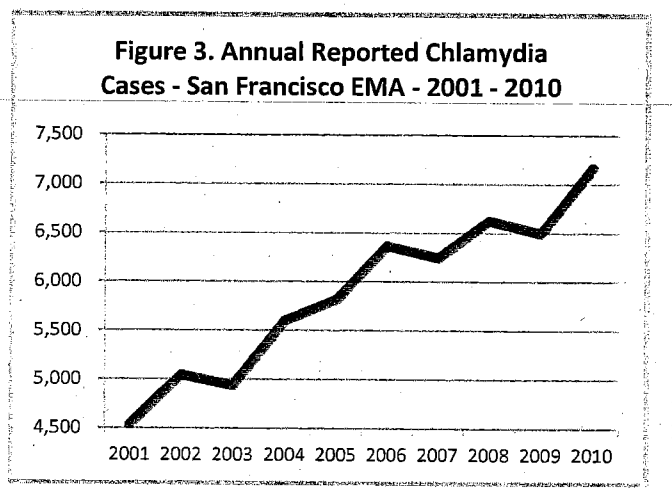
**Sexually Transmitted Infection (STI) Rates:** The growing crisis of **sexually transmitted infections** is of significant concern for the future of the HIV epidemic in our region. In terms of **syphilis,** for example, the San Francisco EMA continues to confront an epidemic that has been escalating for the past half decade, **rising more than 500% since 2000.** The total of **391** new primary and secondary syphilis cases diagnosed in the EMA in 2010 represents a **70.7% increase** over the **229** cases reported in 2007 and exceeds the **364** cases reported in 2004, attesting to a resurgence of the crisis in the region and the difficulty involved in containing or reducing it.[18] Within the City of San Francisco alone, a total of **366** new syphilis cases were reported in 2009, an **82% increase** over the **202** cases diagnosed in 2007. The 2010 syphilis incidence rate of **42.6** cases per 100,000 in San Francisco is **more than eight times higher** than the statewide rate of **5.3** cases per 100,000 and **6 times higher** than the national syphilis rate of

**4.6** cases per 100,000 in 2009 (see Figure 2). San Francisco County has by far the largest rate of syphilis infections of any county in California, more than **five times** the rate of San Diego County (**8.5** per 100,000); more than **six times** that of Los Angeles County (**6.6** per 100,000); and nearly **ten times** the rate of Santa Clara County (**4.5** per 100,000).[19]




The EMA is also experiencing a significant **gonorrhea** epidemic. A total of **2,213** new gonorrhea cases were identified in the San Francisco EMA in 2010, for an EMA-wide incidence of **124.6** cases per 100,000, roughly **100% higher** the 2010 California rate of **69.1** cases per 100,000.[20 21] San Francisco's 2010 gonorrhea incidence of **225.3** cases per 100,000 is **more than double** the 2009 national rate of **99.1** cases per 100,000 and is **325% higher** than the statewide rate, and is again by far the highest rate of any county in California, with the next highest county – Alameda County - having a case rate that is roughly **half** that of San Francisco (**121.5** per 100,000). Many of the EMA's new gonorrhea cases are occurring among **young women aged 15 – 24,** who accounted for **188** cases in 2010. The gonorrhea rate of **638.0** per 100,000 among 15-24-year-old women in San Francisco is **164% higher** than the statewide rate of **241.6** per 100,000.[22]

The San Francisco EMA's **Chlamydia** epidemic also continues to rise precipitously, although rates in EMA are more comparable to national and statewide averages. A total of **7,170** new cases of Chlamydia were diagnosed in the San Francisco EMA in 2010. This represents a **23.3% increase** over the **5,816** cases diagnosed in 2005 and a significant**44%** increase since 2001; although it also represents a slight reduction from the **6,627** cases identified in the EMA in 2008 (see Figure 3).[23] The 2009 EMA-wide Chlamydia incidence stood at **382.4** per 100,000, while the rate for the City of San Francisco was **490.2** cases per 100,000. By comparison, the 2009 incidence for California was **380.6** cases per 100,000.




**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.**[24] 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.[25] 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.**[26] Such studies suggest that the total cost of treating new STIs in the SF EMA may be as high as **$12.38 million** per year, including an estimated **$2.87 million** to treat STIs among persons with HIV, with another **$4.5 million** in annual costs potentially resulting from the need to treat persons infected with HIV as a result of transmission facilitated through other STIs.[27]

**Housing and Homelessness: Housing is an indispensable link in the chain of care for persons with HIV.** Without adequate, stable housing it is virtually impossible for individuals to access primary care; 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]

Figure 4.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs, 2010[28]

| County | Hourly Wage Needed to Rent a Two-Bedroom Apartment at HUD Fair Market Rents |
|---|---|
| San Francisco County, CA | $ 33.85 |
| Marin County, CA | $ 33.85 |
| San Mateo County, CA | $ 33.85 |
| Honolulu County, HI | $ 32.77 |
| Nantucket County, MA | $ 32.37 |
| Santa Cruz County, CA | $ 31.85 |
| Westchester County, NY | $ 31.17 |
| Orange County, CA | $ 30.65 |
| Suffolk County, NY | $ 30.62 |
| Nassau County, NY | $ 30.62 |

**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 2010* 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 hourly wage needed to rent a two-bedroom apartment, which currently stands at **$33.85 per hour** (see Figure 4).[30] Meanwhile, the SF Area has the **highest HUD-established Fair Market Rental rate in the nation**, representing the amount needed to "pay the gross rent of privately owned, decent, and safe rental housing of a modest nature".[31]

On January 27, 2011, the City of San Francisco conducted its bi-annual 24-hour homeless count which identified a total of **6,455** homeless men and women living on the streets or in jails, shelters, rehabilitation centers, or other emergency facilities, a slight decrease from the 2009 total of **6,514.**[32] 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.**[33] 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.[34] 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 **26,640** individuals experience homelessness at some point during the year in the EMA, including an estimated **13,500** chronically homeless individuals and **13,140** temporarily homeless persons.

**Homelessness has a distinct and well-established link to HIV disease.** HIV prevalence studies among homeless adults in San Francisco have produced estimates ranging from a **9%** HIV prevalence rate among the general homeless adult population[35] to an astounding **41%** among marginally housed adult MSM.[36] 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[37] to **68%** among gay and bisexual male teens who enter homeless youth centers.[38] **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 3% in 1992 to 11% in 2007, a nearly fourfold increase.**[39]

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.[40] 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.[41] Overall, SF DPH estimates that the total costs of homelessness add at least an additional **$16.0 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.[42]

**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 in our state and region who benefit from health insurance coverage. California is now in the process of implementing its "Bridge to Reform" Section 1115 Medicaid Demonstration Waiver program, which 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, and the future of coverage is uncertain for many populations. According to data from the UCLA Center for Health Policy Research, an estimated **11.1%** of San Francisco EMA residents under the age of 65 are believed to be without **any** form of insurance coverage - including Medicaid - for a total of at least **188,772** uninsured individuals under 65 in our region (persons 65 and older are excluded as they become eligible for age-based Medicare).[43] This includes an estimated **13.4%** uninsured in San Francisco; **10.8%** uninsured in San Mateo County; and **14.1%** uninsured in Marin County.

**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 **$85.6 million** annually, based on an average **25.1%** uninsured rate among PLWHA in care (n=**4,279**) 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. While detailed poverty data has not yet been released from the 2010 Census, using poverty data from the 2000 Census updated to the region's 2010 population, SF DPH projects that **916,615** individuals in the San Francisco EMA are living at or below 300% of Federal Poverty Level, which translates to **51.6%** of the overall EMA population lacking resources to cover all but the most basic expenses.[44] **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=**15,786**) are living at or below 300% of the 2011 Federal Poverty Level (FPL) including persons in impoverished households. **100%** of Ryan White-funded clients live at or below 300% of poverty.[45] ARIES data reveals that **45.2%** of active Ryan White clients in San Francisco are currently living on incomes of **less than $10,000 per year** and **17%** are surviving on incomes of less than $5,000 per year. HIV-infected persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **$108 million** in Part A and non-Part A HIV-related expenditures in the San Francisco EMA each year.[46]

### 1.b.iii) Impact of Recently 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 **5,134** persons are held in jail settings each day in the San Francisco EMA, while a minimum of **65,000** annual bookings take place in the three-county region. Data for Forensic AIDS Project shows that a total of at least **646** formerly incarcerated individuals received Ryan White services at the agency over the three-year period from July 1, 2008 through June 30, 2011, representing approximately **7.9%** of the City's total Ryan White-funded caseload. This represents a three-year past incarceration rate of **7,906** 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, 2008 through December 31, 2010 a total of **19** new AIDS cases diagnosed at San Quentin Prison, while a total population of **357** persons living with HIV and AIDS were served by the prison as of December 31, 2010. More than two in five of these inmates (**42.3%**) were infected through injection drug use alone, as compared to **7.3%** of all persons living with HIV/AIDS in the EMA. **African Americans** are highly overrepresented among the San Quentin HIV population, representing **49.6%** of all PLWHA at the facility as of 12/31/10.

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 **646** HIV-positive individuals served by Forensic AIDS Project and released from SF jails in the three years through June 30, 2011, **12.4%** were **women – double** the percentage of women living with HIV/AIDS in the EMA (**6.2%**) – and **6.2%** were **transgender persons – nearly three times** their representation among the EMA's total PLWHA population (**2.2%**). Reflecting high rates of injection drug use among incarcerated populations, **33.6%** of persons with HIV in the SF jail system had been infected through injection drug use alone, as compared to **7.3%** of the overall PLWHA population, while MSM / IDU cases accounted for **21.8%** of jail populations, versus **13.9%** 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.[47] Equally alarming is the over-representation by **African Americans** among formerly incarcerated persons with HIV in SF, who account for **50.0%** of all PLWHA diagnosed with HIV or provided with HIV care in San Francisco jails, despite making up **13.6%** 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 new 2009-2012 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.[48]

## 1.c.) Impact of Part A Funding: Funding Mechanisms and the Impact Of the Decline in Ryan White Formula Funding

**1.c.i) Report on the Availability of Other Public Funding:** See **Attachment 5.**

**1.c.ii) 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. As with the Ryan White streams listed above, the Planning Council reviews annual service category summaries that include a detailed listing of all 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. In documents provided by the State of California for this year's Part A application, a total of **$58,469,157** in HIV-specific Medi-Cal expenditures were reported for the three counties of the San Francisco EMA for the 6-month period between January 1 and June 31, 2011, resulting in a 12-month projection of **$116,938,314** for calendar year 2011. For the first time, **over one-half (52.0%)** of HIV Medi-Cal expenditures in the San Francisco EMA during the first six months of 2011 were for **HIV-related medications** (**$30,411,407**); another **17.1%** (**$9,974,674**) were for **inpatient care; and 16.8%** (**$9,818,282**) were for **intensive and skilled nursing care.** The remaining **14.1%** were dispersed among other categories. A total of **6,106** unduplicated HIV-positive individuals were listed as Medi-Cal recipients for the period January 1 – June 30, 2011, an increase of **11.2%** over the 5,491 beneficiaries reported for the first half of 2009. 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 2011 National ADAP Monitoring Report, total ADAP expenditures in California for calendar year 2010 totaled **$436,930,287,** by far the largest ADAP budget in the nation and **58.0% more** than the next highest state, New York, at $276,605,700.[49] At the same time, California's state contribution to the program totaled **$126,019,004**, also by far the largest contribution by any state in the nation, making up **over one-third (36.4%)** of combined state ADAP contributions nationally, and representing a remarkable **77.8%** increase over the $70,859,000 in ADAP funding provided by California in 2009. A total of **34,963** Californians were enrolled in ADAP as of June 2010, versus 19,051 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. Even a slight funding reduction would have drastic consequences for the tens of thousands of individuals who rely on this funding to keep them alive.
- 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 2010, the total HOPWA allocation for the San Francisco EMA totaled **$9,782,816,** including **$8,564,816** for San Francisco County; **$878,500** for San Mateo County; and **$339,500** 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 5).

**Figure 5. 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 County | $ 710,140 | $ 2,909,365 | $ 96,000 | $ 1,185,617 | $ 1,062,497 | $ 8,564,816 |
| San Mateo County | | $ 269,459 | $ 26,000 | | | $ 878,500 |
| Marin County | | $ 136,364 | $ 26,000 | | | $ 339,500 |
| **TOTAL** | **$ 710,140** | **$ 3,315,188** | **$148,000** | **$ 1,185,617** | **$ 1,062,497** | **$ 9,782,816** |

## 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.

**Figure 6.**
**Persons Living with HIV/AIDS Age 50 and Above in San Francisco County as of 12/31/10**

| Demographic Categories | Number | Percent |
|---|---|---|
| **Gender** | | |
| Male | 7,684 | 93.1% |
| Female | 447 | 5.4% |
| Transgender | 121 | 1.5% |
| **Current Age** | | |
| 50 – 59 Years | 5,839 | 70.8% |
| 60 - 69 Years | 2,075 | 25.1% |
| 70 - 79 Years | 298 | 3.6% |
| 80 - 89 Years | 38 | 0.5% |
| 90 and Above | 2 | 0.0% |
| **Ethnicity** | | |
| White | 5,747 | 69.6% |
| African American | 1,226 | 14.9% |
| Latino | 916 | 11.1% |
| Asian / Pacific Islander | 255 | 3.1% |
| Other / Unknown | 108 | 1.3% |
| **Transmission Categories** | | |
| MSM | 6,202 | 75.2% |
| Injection Drug Users | 679 | 8.2% |
| MSM Injection Drug Users | 1,005 | 12.2% |
| Non-IDU Heterosexuals | 198 | 2.4% |
| Other / Unidentified | 168 | 2.0% |
| **TOTAL** | **8,252** | **100.0%** |

**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, 2010, more than two out of every five persons living with HIV and AIDS in the San Francisco EMA (42.6%) were 50 and older (9,787 persons). At the same time, for the second year, persons 50 and older make up more than half of all persons living with AIDS in the EMA (6,039 out of 11,464 persons / 52.7%).** An analysis conducted for this application of the **8,252** persons age 50 and above living with HIV/AIDS as of December 31, 2010 in San Francisco County (see Figure 6) revealed many startling facts about this population, including the fact that there are **338** PLWHA age 70 and above in SF, including **38** persons ages 80 - 89 and **2** persons age 90 and above. The 50 and over population in San Francisco also contains a slightly higher percentage of African Americans than in the PLWHA population as a whole (**15.5%** vs. **13.2%**), along with a

higher proportion of non-MSM injection drug users (**8.7%** vs. **6.6%**). 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 **$156,600,000**.[50]

**Figure 7.**
**MTF Transgender Persons Living with HIV/AIDS in San Francisco County as of 12/31/10**

| Demographic Categories | Number | Percent |
|---|---|---|
| **Current Age** | | |
| 13- 24 Years | 11 | 2.5% |
| 25 - 49 Years | 311 | 70.2% |
| Age 50 and Above | 121 | 27.3% |
| **Ethnicity** | | |
| White | 95 | 21.4% |
| African American | 157 | 35.4% |
| Latino | 136 | 30.7% |
| Asian / Pacific Islander | 43 | 9.7% |
| Other / Unknown | 12 | 2.7% |
| **Transmission Categories** | | |
| MSM | 226 | 51.0% |
| Injection Drug Users | 6 | 1.4% |
| MSM Injection Drug Users | 201 | 45.4% |
| Non-IDU Heterosexuals | 6 | 1.4% |
| Other / Unidentified | 4 | 0.9% |
| **TOTAL** | **443** | **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.[51] 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.[52] What is not in question, however, is the epidemic's growing impact on these populations. As of December 31, 2010, at least **500** transgender persons were living with HIV and AIDS in San Francisco and Marin Counties (the County of San Mateo does not break out transgender HIV cases separately). The actual numbers, however, are probably much higher, with some studies indicating that HIV infection rates may be as high as **23.8%** among this population, which in San Francisco would mean that at least **1,200** transgender persons may already be living with HIV.[53] Figure 7 provides a demographic breakdown of the PLWHA male-to-female (MTF) transgender population in San Francisco County as of 12/31/10 and offers some fascinating insights into the

complexity of this population. Perhaps most striking is the **cultural diversity** of transgender PLWHA, with the largest infected ethnic groups being **African Americans (35.4%)** and **Latinos (30.7%).** Together these groups make up **66.1%** of transgender PLWHA but only **30.4%** of all PLWHA in the EMA. Reflecting the high risk of injection-related infections among transgender persons, fully **45.4%** of transgender PLWHA were infected through combined MSM / IDU behavior, versus **13.9%** for the EMA as a whole. 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.[54] **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. **The San Francisco Planning Council is currently conducting an intensive Transgender Needs Assessment that is expected to yield critical information to improve the quality and effectiveness of care for these populations.** The annual **cost** of providing HIV-related services to transgender persons in the San Francisco EMA is estimated to be at least **$5,700,000** per year.[55]

**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 **86.0%** of all persons living with HIV and AIDS as of December 31, 2010, including MSM who inject drugs (n=**19,717**). 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 2010, nearly half of all persons who tested positive for HIV (**48.0%**) were persons of color, an increase of **5.8%** from 2006. 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 **$72,000,000**.[56]

**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 **1,605** HIV-infected homeless individuals are estimated to be living with HIV or AIDS in the San Francisco EMA each year (based on an overall 7% homelessness rate among PLWHA), and at least **42%** of them are estimated to be out of care. Because of their disconnection from health and social service systems, homeless individuals are the population **least likely** to obtain regular health or preventive care. **Clearly, the most pressing 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. The annual **cost** of providing HIV-related services to homeless persons in the SF EMA is estimated at **$19,260,000.**[57]

**Emerging Population # 5: African Americans:** The growing crisis of HIV among African Americans in the San Francisco EMA is a cause for significant concern. As of December 31, 2010, a total of **3,119** African Americans were estimated to be living with HIV/AIDS in the EMA, representing **13.6%** 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 **18.4%** of all those diagnosed with AIDS between January 1, 2008 and December 31, 2010 were African American – a percentage **35.3%** 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 **6.2%** for the EMA as a whole, while heterosexually transmitted cases account for **9.7%** of African American PLWHA as compared to **3.6%** for the entire EMA. At least **35%** of all African Americans living with HIV in the San Francisco EMA are currently estimated to be out of care - a proportion comparable to the percentage of homeless persons out of care. The reasons for this under-representation include: a) 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 **$38,178,000.**[58]

**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 **16.8%** of all PLWHA in the EMA as of December 31, 2010 were Latino/a, **10.7%** of new AIDS cases diagnosed between January 1, 2008 and December 31, 2010 were among Latino/as, with a total of **3,854** Latino/a PLWHA estimated to be living in the EMA as of the end of 2010. 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 **$48,564,000.**[59]

## 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; 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 **23,928** persons living with HIV and AIDS as of 12/31/10 represents **73.1%** of the total 32,742 AIDS cases **ever diagnosed** in the San Francisco EMA, and is **9.2% more** than the 21,910 people who had **ever died** from AIDS in the region through the end of 2010. 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;[60] **One in four** persons with HIV have no form of health insurance;[61] Nearly **one in ten** persons newly diagnosed with AIDS in the EMA is homeless;[62] As many as **half** of MSM living with HIV in the EMA suffer from depression;[63] **Thirty percent** of local PLWHA are active substance users;[64] **One in seven** persons with HIV in the EMA speaks a primary language other than English;[65] **As many as one-third** of gay-identified men in the San Francisco EMA may be HIV-infected;[66] **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.[67]

**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.[68]

**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

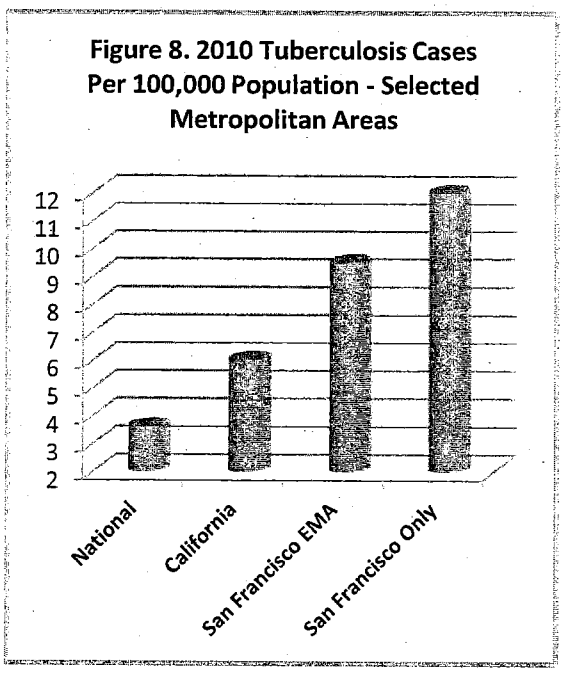
fueling the spread not only of HIV but of co-morbidities such as sexually transmitted infections, hepatitis C, mental illness, and homelessness - conditions that complicate the care system's ability to bring and retain PLWHA in care. According to the most recent report by the California Office of Statewide Health Planning and Development, an average of **8.5** hospitalizations per 10,000 occurred in San Francisco from 2006 to 2008, well above the average statewide rate of **6.6** per 10,000.[69] Over 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.[70] 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**.[71] 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,[72] and recreational crystal use has been linked to **30%** of San Francisco's new HIV infections in recent years.[73]

The costs associated with the substance addiction epidemic in the San Francisco EMA add significantly to the local burden of HIV care. According to the National Office of Drug Control Policy, the nationwide societal costs of drug abuse in the year 1998 alone totaled **$143.4 billion.**[74] 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.**[75] Such costs can be significantly offset by drug treatment services, which are estimated to save between **$4** and **$7** for every dollar spent on treatment. An average course of methadone maintenance therapy, for example, costs about **$290** per month, while a range of methamphetamine treatment programs currently operating in San Francisco cost between **$2,068** and **4,458** for a single course of treatment.[76]

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.[77] 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.**[78] 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.**[79] **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 HIV care system.**

**Tuberculosis (TB)** is another critical health factor linked to HIV, particularly in terms of its effects on recent immigrants and the homeless. The magnitude of the local TB crisis is comparable to syphilis and gonorrhea, with a total of **168** new cases of TB diagnosed in the SF Metropolitan Area in 2010, representing an EMA-wide incidence of **9.5** cases per 100,000.[80] In San Francisco, the incidence is even higher, at **12.0** cases per 100,000. **The city's TB incidence rate is double than the statewide rate of 6.0 cases per 100,000 and nearly 350% higher than the national rate of 3.6 cases per 100,000** (see Figure 8).[81] 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.[82]




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.[83] 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.[84] 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%.**[85] 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.[86]

**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 41** 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

While the San Francisco EMA did not experience a loss in Part A formula funding between the 2010 and 2011 Ryan White fiscal years, the region has been hard-hit by 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. Additionally, the hold harmless provision of the Ryan White HIV/AIDS Treatment Extension Act of 2009 between 2010 and 2014 also does not include a supplemental funding restoration to the San Francisco EMA, which translates to a potential 5% cut to formula portion of the RWPA award. The lack of security for level formula funding for the EMA has created a sense of instability in the system and obstacles to planning responses to emerging needs. Continual reductions in formula and supplemental funding over the past half decade have 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 the Tenderloin Health Services 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. Prior Part A funding reductions 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 will now consist of food gift cards made available to only the most severe need clients who must now shop for and prepare their own meals. At the same time, on-going efforts to identify and bring into care new persons with HIV who are unaware of their status will also place additional burdens on a system already stretched to the breaking point. **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 2012 allocation process in order to avoid significant reductions in the quality and length of life of persons with HIV in the region.**

## 1.g) UNMET NEED

### 1.g.i) Unmet Need Framework - See Table in Attachment 6

### 1.g.ii) 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, 2009 through June 30, 2010.** 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 HIV/AIDS Statistics and Epidemiology Section, and utilize the unmet need framework methodology developed by the University of California, San Francisco Institute of Health Policy Studies – the framework 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, SF DPH also obtained a file containing patient-level care information for the EMA from the California State eHARS system, Medicaid (Medi-Cal), 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 **very complete**. For all counties in the SF EMA, the number of PLWA was derived directly from AIDS cases reported in eHARS. SF DPH calculates the number of PLWH in San Francisco (which contains close to **90%** of the EMA's total PLWA population) and San Mateo based on the actual number of PLWH already contained in eHARS, supplemented by additional PLWH from the California patient care file (described above in Data Sources) and a laboratory data file containing patients with confirmed HIV test results who had not yet been reported in eHARS. The total number of PLWH documented in these files after unduplicating across data sources was used. The number of PLWH in Marin County was estimated based on two assumptions: (1) a **1-to-1 ratio** of PLWA to PLWH based on consensus estimates obtained in 2010 from HIV/AIDS experts[87]; and (2) an estimation that **66%** of PLWH in the EMA were aware of their HIV infection (based on a recent analysis comparing consensus estimates and case report data). 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 4) because they receive a diagnosis of HIV within our EMA.[88]

**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, 2009 through June 30, 2010**. Separate unmet need estimates for PLWA and PLWH were able to 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 using a representative subset of PLWA living in San Francisco County (n=7,900) was calculated. The proportion of PLWA in care was determined primarily based on the date of the last time the patient was seen and recorded by the Health Department. The sample proportion of PLWA in care to the total number of PLWA was then applied to derive the number of PLWA who received care within each of these two counties. For all counties in the EMA, the number of PLWH in care was calculated as the number of unduplicated persons who received care based on all data sources. Estimates for PLWA and PLWH were first derived separately for each of the three EMA counties and then combined to produce the EMA estimates shown in the unmet need table in Attachment 6.

**Findings: Estimates of Populations, Persons in Care and Unmet Need from July 1, 2009 through June 30, 2010:** An estimated **11,981** PLWA and **9147** PLWH who were aware of their HIV status resided in the S.F. EMA from July 1, 2009 through June 30, 2010 (see Table in Attachment 7). A total of **1,203** PLWA and **1,695** PLWH did not receive primary medical care during that time period. Unmet need was thus **14%** overall, and - as would be expected - was

higher among PLWH (**19%**) than among PLWA (**10%**). The 14% overall unmet need estimate is lower than last year's estimate of 18%.

### 1.g.iii) Unmet Need Trends

The table below lists percentage of unmet need in San Francisco for the years 2008–2010, 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 demonstrates a significant decrease in the percentage of persons out of care in the EMA, from 23% in FY 2008 to 18% in FY 2009 to 14% in FY 2010.** 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.

| Reported Percentages of Unmet Need in San Francisco EMA – FY 2008 - FY 2010 | | |
|---|---|---|
| **FY 2008-2009** | **FY 2009-2010** | **FY 2010-2011** |
| **23%** | **18%** | **14%** |

### 1.g.iv) Incorporation of Unmet Need Trends in Local Planning

The San Francisco HIV Health Services Planning Council annually reviews 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 an emphasis on specifically assessing unmet HIV service needs, and yielded 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. The Planning Council utilizes unmet needs data both to target the EMA's outreach and care linkage activities to persons who have fallen out of care, and to anticipate future trends regarding HIV care populations who may enter the system in the coming years.

### 1.g.v) Unmet Need Data and Utilization

**Methods to Assess Needs, Gaps, and Barriers for Persons Not in Care:** Continually improving and refining the process of determining unmet need - and doing so in a manner that allows the local Planning Council to allocate funds that bring the greatest number of out-of-care individuals into care - remains a high priority for the San Francisco EMA. One of the most important approaches the EMA uses to accurately quantify the full number of persons living with HIV in the region - particularly since HIV reporting did not begin in California until July of 2002 - involves the use of **consensus meetings** in which local and regional researchers, epidemiologists, and community providers participate in a process to estimate the number of persons with HIV living in each of the EMA's counties as a proportion of the total number of persons living with AIDS. The most recent consensus process, conducted in 2011, resulted in a sound estimate of the PLWH populations of both San Mateo and Marin Counties. Meanwhile, continual improvements in the utilization of the eHARS reporting system by the City and County of San Francisco enabled the utilization of **eHARS data only** as a basis for quantifying the total number of non-AIDS PLWH living in the city. This allows for the production of much more

accurate and detailed representations of PLWH. The ability to accurately quantify the local PLWH population is expected to continue to improve over time.

One of the outcomes of our improved data collection and reporting systems is the ability to compare specific unmet need among PLWHA across **four** critical categories: **HIV/AIDS status, gender, race/ethnicity,** and **age group**. Among all PLWHA populations, analysis reveals that unmet need was similar for males and females and across race/ethnicity and age categories, attesting to the expanding success of our programs in reaching diverse ethnic populations. Also, as is to be expected, the proportion of persons reporting an unmet need was significantly higher among those with non-AIDS HIV (**19%**) than among those diagnosed with AIDS (**9%**), reflecting the fact that the vast majority of persons diagnosed with AIDS is currently in care. However, in terms of age, PLWHA **adults aged 30-39** were most likely to have unmet need for medical care than other age groups (**19%**), while significant unmet need also exists among persons **29 years and below.** Persons **aged 60 years or older** were **least** likely to have unmet need (**7%**). **These findings point to the urgency of expanding outreach and service linkage programs related to young adult and recently diagnosed populations.** In terms of youth, the San Francisco EMA service system has for many years been actively engaged in efforts to expand mobile and alternative approaches to HIV testing, and in systems such as the new PHAST Program that **immediately** link to care individuals who test positive in both public and private settings. The EMA has developed cooperative education and outreach programs in collaboration with regional prevention providers - programs that have consistently expanded the proportion of young people who enter the care system annually. At the same time, innovative approaches such as the Centers of Excellence model are specifically designed to expand awareness of and access to HIV services among young people within ethnic minority communities in San Francisco County, and to overcome barriers to care resulting from distrust of the medical system, fear of disclosure of HIV status, and fear of not receiving culturally appropriate services.

**Efforts to Identify People Not in Care and Assist Them in Accessing Primary Care: Results of the Unmet Needs Framework analysis were presented to the San Francisco HIV Health Services Planning Council during the prioritization and allocation process, and played a critical role in helping influence and shape service category and funding decisions for FY 2012.** For example, findings related to unmet need among ethnic minority populations helped to reinforce the approach of funding Centers of Excellence that create centralized service structures for severe need and hard-to-reach populations, particularly Latinos and African Americans. Findings related to unmet need among young people influenced the decision to continue to prioritize substance abuse services in this year's Part A Plan, in order to address substance addiction barriers that can limit young people's willingness to access HIV testing and care. The Unmet Needs Framework remains a seminal document through which the Planning Council determines how best to allocate resources to bring more persons with HIV into care and to create service responses that meet the needs of expanding populations.

## 2. EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA)

### 2.a) EIIHA Strategy

### 2.a.1) Strategy to identify Individuals Who Are Unaware of HIV Status

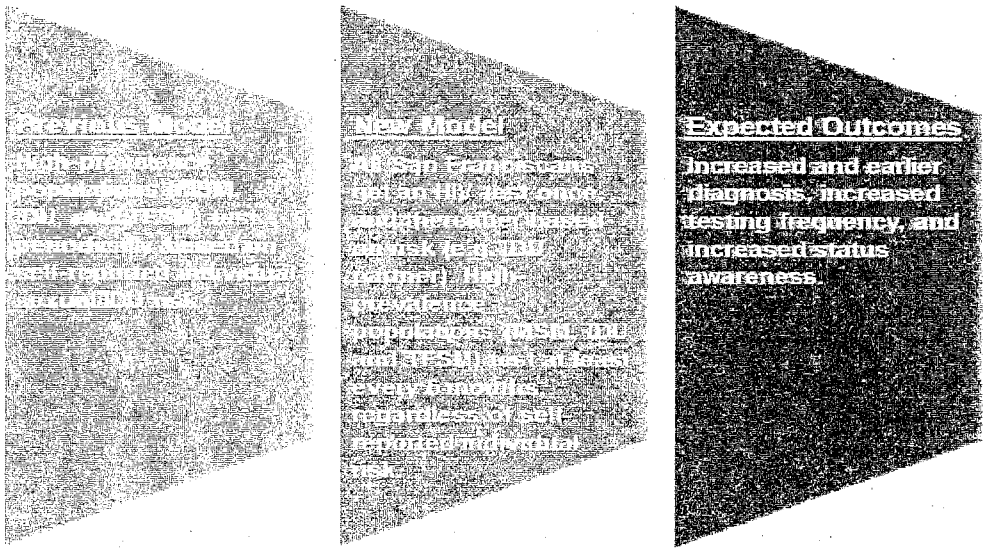
**a) Specific Goals of the Strategy:** The San Francisco EMA oversees a well-developed system of HIV prevention and early intervention services that incorporates extensive public / private partnerships and employs innovative, cutting-edge approaches to reach, identify, and link persons with HIV who are 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-testing counseling in public and private settings to service referral and linkage to care. Under the leadership of the San Francisco HIV Prevention Section (HPS) and the San Francisco HIV Prevention Planning Council, San Francisco has also developed complex 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.[89] 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 service and support.

As of September 1, 2011, the San Francisco HIV Prevention Section has put into place a comprehensive set of integrated prevention and care linkage strategies based on priorities outlined in its **2010 Comprehensive HIV Prevention Plan** and on activities enumerated through its most recent prevention **request for proposals (RFP).** These programs center on the goal of **reducing new HIV infections in San Francisco by 50% by the year 2017**.[90] To attain this goal, the County RFP focuses on **five** key objectives that addressed high prevalence subpopulations which statistically comprise the bulk of the local epidemic: 1) Reduce new HIV infections among men who have sex with men by 50**%**; 2) Reduce new HIV infections among transpersons by **50%;** 3) **Eliminate** new HIV infections among IDUs; 4) **Eliminate** perinatal HIV infections; and 5) Reduce disparities in new HIV infections.

**The first priority area of the 2010 HIV Prevention Plan entitled "HIV Status Awareness" is specifically directed toward HIV-unaware populations. The goal of this priority area – which also serves as the EIIHA goal for the EMA - is "to promote knowledge of HIV status and link all people who have HIV to medical care and support services."** The goal is consistent with the need to make individuals who are unaware of their HIV status aware of their infection. The San Francisco HIV Prevention Section has also established a new set of recommendations for HIV testing frequency depicted in the chart on the following page. These will be fully reviewed within the Department of Public Health and then disseminated to providers and the community via social marketing and other methods. The new approach mirrors a key vision of the HIV Prevention Plan that HIV testing should be frequently utilized, widely accessible, client-centered, and responsive to the community. The Prevention Plan also articulates a complex set of rationales for prioritizing HIV status awareness activities, and prioritizes partner services and linkage to medical care as indispensable components in the HIV status awareness process.

The goals and objectives of the TGA's EIIHA plan are fully consistent with 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.[91] 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.




**b) <u>Coordination with Other Programs, Facilities, and Community Efforts</u>:** 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 prisoner 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 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 the HIV Prevention Section 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, two new **ECHPP Liaisons** – one within HIV Health Services funded through ECHPP and one within Community Behavioral Health Services funded through MAI Targeted Capacity Expansion (TCE) funding – are specifically dedicated to ensuring that the services overseen by these two units are fully coordinated.

At the community planning level, the San Francisco HIV Health Services Planning Council ensures coordination between HRSA and CDC-funded programs through the Council's **Points of Integration Between Prevention and Health Services Committee.** This group is a joint

committee of the HIV Health Services Planning Council and the HIV Prevention Planning Council and its work is guided by two key questions: 1) How can prevention and care work together to improve both HIV prevention and HIV health services? 2) How can the committee support prevention with positives (PWP) services in San Francisco? The committee serves as the key conduit of information between the two councils, continually sharing information and data which is in turn passed on to the two planning bodies. The committee also explores issues common to prevention and care, including the need to identify unaware populations and link them to care. It also designs collaborative strategies for more fully integrating regional prevention and service efforts.

c) **Incorporation into Request for Proposals:** Information on HIV outreach, testing, and service linkage for unaware persons has consistently been a component of Part A RFPs in the San Francisco EMA. Last year's RFP for Centers for Excellence services in San Francisco, for example, incorporates a distinct funding category for **prevention with positives** services that includes an emphasis on encouraging HIV testing among the social, sexual, and drug using network members of HIV-positive individuals. These PwP efforts will be supported with CDC HIV prevention funding, resulting in expanded and integrated PWP efforts at its Centers of Excellence. Over the coming years, EIIHA-based information and requirements will also play an increasingly pivotal role in County RFAs as the region emphasizes a more aggressively integrated relationship between prevention and care, and a broader integration of HIV outreach, testing, and linkage services into HIV primary care.

d) **Consideration of ADAP and Other Medication Resources:** In the long run, the enrollment of expanded numbers of low-income persons with HIV into local Ryan White services has the potential to significantly reduce the cost of the AIDS epidemic by reducing the incidence of new HIV cases in the future and by reducing costs related to advanced HIV infection. In the short run, however, expanded HIV populations will place additional burdens on a care system already struggling to provide quality care. The recent expansion of Medi-Cal and health care coverage to low-income persons living at or below 200% of FPL through the California 1115 Medicaid Demonstration Waiver will play a critical role in helping support the cost of medications for persons newly linked to the HIV care system through enhanced testing and linkage programs. At the same time, however, the preservation and expansion of ADAP programs and other medication support services will continue to play a critical role in ensuring the system's ability to preserve the health status of low-income and uninsured clients and reduce community viral load which can in turn impact the future of the epidemic. Thus far, in spite of a severe economic crisis, California has continued to support the ADAP program in a manner that has obviated the use of local Part A funds to cover HIV medications costs. Nevertheless, expanding HIV populations coupled with declining public resources have the potential to change the Planning Council's need to allocate Part A funding for HIV medications in the future.

e) **Addressing Disparities in Access and Services:** 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.

**f) Programmatic, Systemic, and Logistical Challenges:** 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.

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 routinized 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? 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.

**g) Role of Ryan White Programs in Facilitating Routine HIV Testing:** Ryan White programs play a critical role in facilitating access to routine HIV testing in the San Francisco EMA. Some Ryan White-funded primary care sites are based at hospital facilities and other large medical programs that provide opt-out or routinized HIV testing. Providers at these sites offer critical TA and support functions while ensuring an on-site conduit to immediate care for persons who test positive. Other Ryan White agencies offer their own forms of routinized in-house testing or advocate for the adoption of expanded HIV testing programs within their agencies. Virtually all Ryan White-funded primary medical care and case management sites are available to meet the needs of newly identified persons with HIV and maintain referral relationships with testing providers to facilitate transfer and linkage to care, including transporting newly diagnosed persons directly to care and treatment facilities. Ryan White programs also serve as strong local advocates for the policies that promulgate expanded HIV testing within the EMA.

**h) Coordination with Ryan White Part C Funding:** The San Francisco HIV Health Services Planning Council closely monitors the distribution and utilization of Part C funding resources in the San Francisco EMA, including reviewing and considering data on Part C service units and allocations as part of its annual prioritization and allocations process. Many of the

organizations receiving Ryan White Part A funding in the EMA are co-recipients of Part C support, and these providers are required to report on Part C allocations and service provision as a condition of contract award. Being co-recipients of Part A and Part C funding also means that many local Part C-funded agencies participate in the Ryan White community planning process and are made aware of new developments, standards, and programs to integrate HIV prevention and care through the Planning Council and its Points of Integration working group. Both HIV Health Services and the HIV Prevention Section also extensively publicize new developments in HIV outreach, testing, and care linkage through approaches such as community forums, training and TA, documents, community plans, and best practice and guidelines documents.

## 2.a.2) EIIHA Matrix – Please see Attachment 9

## 2.b) EIIHA Plan

## 2.b.1) Barriers that Obstruct Awareness of HIV Status

a) **Priority Needs that Obstruct Awareness of HIV Status:** The high-risk subpopulations identified by the San Francisco EMA and listed in the EIIHA matrix in Attachment 9 consist 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);** and **4) high-risk non-IDU heterosexual males and females.** Individuals in the first three populations who are affected by one or more of the **HIV drivers** identified in the 2010 San Francisco HIV Prevention Plan are considered at highest risk. The Prevention Plan utilizes the concept of **drivers of HIV infection** to emphasize the fact that HIV risk is linked to specific factors that cross these populations. Prioritized drivers specific to the four identified high-risk subpopulations include: a) cocaine/crack; b) gonorrhea; c) heavy alcohol use; d) methamphetamine; e) multiple partners; and f) poppers. For non-IDU heterosexuals, factors associated with increased HIV risk include STD infection, having an HIV-infected or drug using partner, and a recent history of or current incarcerated status. 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; 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.

b) **Cultural Challenges that Obstruct Awareness of HIV Status:** The San Francisco EMA prioritizes culturally specific HIV testing outreach, referral, and linkage services that are tailored to each cultural group or population in the region. This includes services that are responsive to linguistic needs; that speak to specific cultural concerns, behaviors, beliefs, and conditions; that take into account the impacts of discrimination and disenfranchisement; and that meet clients directly within the communities in which they live. While these issues are necessarily bound up with general population barriers to awareness of HIV status, some of the 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.

## 2.b.2) Activities to Address Barriers to Awareness of HIV Status

**a) Activities to Address Priority Needs that Obstruct Awareness of HIV Status:** Among the specific activities to overcome obstruction to awareness of HIV status among the EIIHA Plan's high-risk subpopulations are the following: a) expand the availability of widespread, frequent, routinized HIV testing in healthcare and other settings; b) promote programs that address homophobia and HIV stigma, and provide support for positive self-awareness among MSM; c) increase and reinforce public awareness of the seriousness of HIV infection and the importance of testing and early intervention, particularly among youth and transgender persons; d) expand the availability of harm reduction approaches to HIV treatment that do not require sobriety as a pre-condition of treatment; and e) expand the availability of community-based testing for homeless persons.

**b) Activities to Address Cultural Challenges that Obstruct Awareness of HIV Status:** Specific activities to address cultural challenges obstructing awareness of HIV status among the EIIHA Plan's high-risk subpopulations include the following: a) expand the availability of culturally competent HIV testing venues that respond to issues specific to MSM and transgender persons of color; b) expand public education and social marketing efforts to overcome HIV stigma and the fear of HIV treatment; c) enhance the ability of HIV service agencies and programs to provide culturally and linguistically competent services to communities of color; and d) expand provider education and training to increase sensitivity and awareness of issues related to HIV-infected MSM, transgender, and substance-using persons of color.

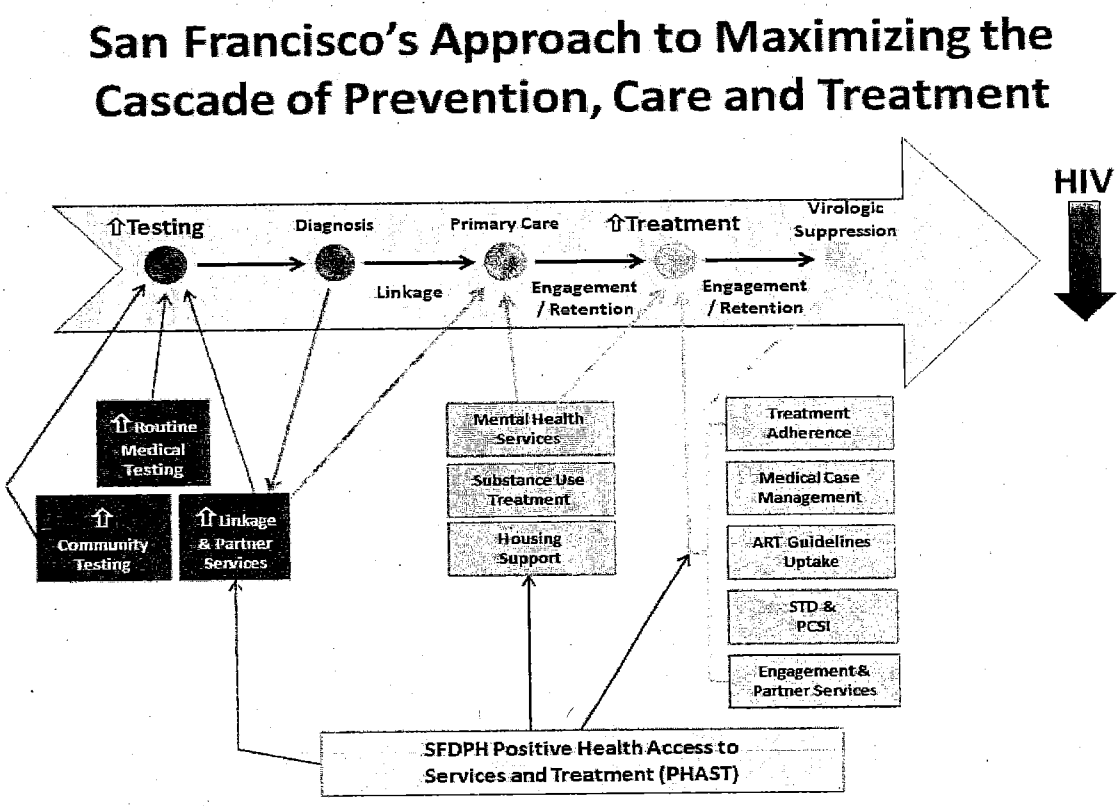
## 2.b.3) Activities Taken to Facilitate HIV Testing in the EMA

**a) Coordination with Other Organizations:** As sister units in the San Francisco Department of Public Health AIDS Office, HIV Health Services works in close partnership with the HIV Prevention Section to plan services, design interventions, and share data and emerging findings. Through its strong working relationship, the two 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 partnership 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 January 1, 2012, the ability to coordinate and scale up HIV testing across all counties is greatly enhanced.

The two SF County agencies and a broad range of related programs and services in the EMA operate through the region's recently developed **Continuum of HIV Prevention, Care, and Treatment** - a model developed through the current Enhanced Comprehensive HIV Prevention Plan (ECHPP) process. 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 new **Positive Health Access to Services and Treatment (PHAST) Program**, an innovative approach to care linkage and retention described in greater detail below.

b) **Role of Early Intervention Services in Facilitating HIV Testing:** Early intervention providers - including providers funded through Ryan White Part C - play a critical role in the testing system by providing expedited care linkage for persons newly identified as having HIV. Many HIV care programs also operate their own in-house HIV testing programs which identify many new HIV-infected individuals each year. Early intervention providers also promote HIV testing within their agencies by encouraging HIV-infected clients to refer members of their social, sexual, and drug-using networks to HIV testing services, including services available directly on-site at these agencies. Early intervention programs also play an important role in HIV prevention and care planning in the EMA by identifying emerging trends within their service populations that help better target prevention resources and services.




## 2.b.4) Identifying, Informing, Referring, and Linking

### 2.b.4.a) Identifying Individuals Unaware of their HIV Status

i) **Activities to Identify New HIV-Positive Individuals:** The San Francisco EMA operates a diverse and integrated range of programs to increase the number of HIV-unaware individuals who are tested for HIV infection each year, with services prioritized based on key identified high prevalence populations. Key overarching activities to identify new HIV-positive persons with the EMA include: a) continually expanding community-based HIV testing for MSM, TFSM, IDU, African American MSM, and Latino MSM (funded with CDC funds through HPS); b)

continually scaling up routine HIV testing in medical settings (structural intervention funded with CDC funds through HPS); c) expanding outreach and social marketing activities targeting both community/patients and medical and social service providers to increase awareness of new recommendations for HIV testing frequency for specific populations (funded with CDC funds through HPS); d) ensuring the broadest possible range of public and private doors into testing across the EMA; e) expanding utilization of partner services by directly offering partner services to all newly diagnosed individuals; f) expanding social network-based testing approaches; g) utilizing mobile testing and venue-based testing to expand testing utilization; and h) enrolling community members/patients in high prevalence populations in text messaging/email testing reminder programs. **The table beginning on the following page describes activities essential to making individuals aware of their HIV status by subpopulation, including information on which essential activities are to be implemented immediately and which activities are proposed but are NOT able to be implemented immediately.**

San Francisco brought about a major enhancement of its HIV testing services matrix this year by implementing the new **SFDPH Citywide Positive Health Access to Services and Treatment (PHAST) program,** modeled on a highly effective linkage/retention program still in operation at San Francisco General Hospital. The Citywide PHAST Team will provide a comprehensive range of services based on individual client needs and circumstances, incorporating linkage to HIV medical care, social services, partner services, and retention services under a single umbrella. The new PHAST program will employ an integrated team of **four to six full-time staff.** Four staff will provide individualized, tailored care linkage and retention services and centralized access to services for the majority of persons testing newly positive in San Francisco. Two of these four PHAST Team members will be based at high-volume citywide testing sites - one at San Francisco's nationally recognized Magnet Clinic and another at AIDS Health Project - while two "rovers" will serve lower-volume community-based testing and medical sites. These PHAST Team members also will remain paired with newly identified individuals in a supportive relationship for up to **three months** following initial HIV diagnosis. These four staff will strive to achieve the following two goals: 1) that linkage to care is made **within 30 days** for **everyone** testing positive in San Francisco; and 2) that **all** newly-diagnosed individuals are offered comprehensive and immediate linkage and partner services. An additional two staff will focus on 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 PHAST Team will play 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 PHAST system, however, each PHAST team member will directly offer 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 PHAST 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 through the PHAST Team members. The incorporation of partner services into the

## FY 2012–2013 San Francisco EMA EIIHA Plan Chart

| EIIHA Activities | Immediately or Already Implemented | To Be Implemented in FY 2012 |
|---|---|---|
| **Note that for all activities below the timeframe is 3/1/12 - 2/28/13 and the parties responsible are the EMA County Prevention Sections** | | |
| **A. Identifying Individuals Who are Unaware of their HIV Status** | | |
| **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 to encourage HIV testing at least every 6 months | | X |
| ▪ Enhance utilization of partner services through local PHAST Teams | 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 to encourage HIV testing at least every 6 months | | X |
| ▪ Enhance utilization of partner services through local PHAST Teams | X | |
| **Transgender Females Who Have Sex With Males:** | | |
| ▪ 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 local PHAST Teams | X | |
| **High-Risk Non-IDU Heterosexual Men and Women:** | | |
| ▪ Expand routine HIV testing in medical settings | X | |
| ▪ Enhance utilization of partner services through local PHAST Teams | X | |
| **B. Informing Individuals of their HIV Status** | | |
| **Males Who Have Sex With Males (MSM):** | | |
| ▪ 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 HIV testing among young MSM and MSM of color and improve return rates for HIV test results, including incorporating MSM programs and outreach into traditional health care settings | X | |

| EIIHA Activities | Immediately or Already Implemented | To Be Implemented in FY 2012 |
|---|---|---|
| **Note that for all activities below the timeframe is 3/1/12 - 2/28/13 and the parties responsible are the EMA County Prevention Sections** | | |
| **Injection Drug Users (IDU):** | | |
| ▪ Provide continual training and re-orientation to HIV testing providers based in alcohol and drug treatment facilities | X | |
| ▪ 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 | |
| **Transgender Females Who Have Sex With Males:** | | |
| ▪ 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 | |
| **High-Risk Non-IDU Heterosexual Men and Women:** | | |
| ▪ Create safe testing and disclosure venues for high-risk heterosexual women in abusive or threatening relationships | X | |
| ▪ Ensure availability of testing programs in appropriate languages for non-English speaking heterosexuals | X | |
| ▪ Incorporate expanded HIV testing in traditional heterosexual service programs and health agencies | X | |
| **C. Referring Individuals to HIV Care** | | |
| **Males Who Have Sex With Males (MSM):** | | |
| ▪ Utilize PHAST 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 | |
| **Injection Drug Users (IDU):** | | |
| ▪ Utilize PHAST 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 | |
| **Transgender Females Who Have Sex With Males:** | | |
| ▪ Utilize PHAST 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 | |

| EIIHA Activities | Immediately or Already Implemented | To Be Implemented in FY 2012 |
|---|---|---|
| **Note that for all activities below the timeframe is 3/1/12 - 2/28/13 and the parties responsible are the EMA County Prevention Sections** | | |
| **High-Risk Non-IDU Heterosexual Men and Women:** | | |
| ▪ Utilize PHAST Team members to provide comprehensive referrals appropriate to non-IDU heterosexual populations | X | |
| ▪ For heterosexual women in abusive or power-imbalanced relationships, ensure referrals to women's support agencies and appropriate partner disclosure support services | X | |
| ▪ Incorporate consideration of transportation and child care issues for heterosexual women with children. | X | |
| **D. Linking Individuals to HIV Care** | | |
| **Males Who Have Sex With Males (MSM):** | | |
| ▪ Utilize PHAST Team members to make, verify, and track linkages to agencies that specialize in MSM health | X | |
| ▪ Through PHAST 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 PHAST Team to ensure client linkage to care | | X |
| **Injection Drug Users (IDU):** | | |
| ▪ Utilize PHAST Team members to make, verify, and track linkages to agencies that specialize in IDU services | X | |
| ▪ Through PHAST 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 PHAST Team to ensure client linkage to care | | X |
| **Transgender Females Who Have Sex With Males:** | | |
| ▪ Utilize PHAST 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 PHAST 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 PHAST Team to ensure client linkage to care | | X |
| **High-Risk Non-IDU Heterosexual Men and Women:** | | |
| ▪ Utilize PHAST Team members to make, verify, and track linkages to care | X | |
| ▪ Through PHAST 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 PHAST Team to ensure client linkage to care | | X |

PHAST Team model is expected to significantly increase the number of new HIV positive individuals identified in the San Francisco region.

**ii) Coordination with Ryan White Part B:** Although not required by HRSA, in San Francisco, the HIV Health Services Planning Council is charged with coordinating Part A and B and services to maximize the impact of both funding streams. This service planning process is in turn coordinated with all units of the San Francisco AIDS Office, including the HIV Prevention Section, in order to enhance regional efforts to identify and link to care persons with HIV who are unaware of their positive status.

**iii) Coordination with Prevention and Disease Control Programs:** All relevant health department partners – HIV Health Services, STD Prevention and Control, HIV Prevention, HIV Epidemiology, and others – meet on a regular basis to identify opportunities for coordination and to maximize and leverage (and not supplant) funding. As mentioned earlier, the Director of Strategic Integration is a dedicated position for ensuring that this coordination happens. The goal is to realize seamless, effective HIV testing programs on the ground. San Francisco's **Magnet Clinic**, for example, has become a nationally recognized model HIV testing outreach program that relies on an extensive public / private collaboration for its success (see magnetsf.org). Overseen by the San Francisco AIDS Foundation, Magnet provides storefront-based rapid HIV testing, STD testing and treatment, and Hepatitis A and B vaccinations in a comfortable, neighborhood-friendly, and sex positive environment in the heart of the Castro neighborhood, incorporating community events, forums, and a drop-in center to normalize and de-stigmatize testing and to encourage individuals to seek services there. The Magnet Clinic's partner roster includes the San Francisco Department of Public Health as well as entities as diverse as the UCSF Center for AIDS Prevention Studies, the Queer Cultural Center, the Merchants of Upper Market & Castro, The Options Project, and Blow Buddies, a major local sex club. Magnet also obtains ongoing input for its development and growth through an active Community Advisory Board that incorporates consumers and community members.

### 2.b.4.b) Informing Individuals of their HIV Status

**i) Activities to Inform Individuals of their HIV Status:** Because all community testing in San Francisco now takes the form of rapid testing, there is a virtually **100% disclosure rate** for HIV test results in the region. However, the San Francisco EMA maintains strict standards for informing persons of their HIV status in the context of the post-test or confirmatory test appointment. Face-to-face disclosure is **mandatory** for all individuals who test positive for HIV, with the following also required for both rapid and conventional testing approaches: a) **follow-up** if a client tests reactive on a rapid HIV test or positive on a conventional HIV test and does not return for his or her result; b) **disclosure of results** to the client, including counseling as to what the result means and what options and support are available to the client; c) **linkage to medical care**, including assistance in making a medical appointment and verifying whether the appointment was kept and medical workup completed, now facilitated through the new Citywide PHAST Team; and d) **partner services and support for** clients with HIV to disclose to sexual and/or syringe sharing partners to alert them to possible exposure. As noted in the new San Francisco Prevention Plan, "the objective of disclosing positive HIV antibody test results is to ensure that individuals testing positive for HIV learn the results of their test and are **immediately linked** to medical and partner services to reduce morbidity and mortality and prevent HIV transmission to others."[92] This approach emphasizes the EMA's commitment to removing unnecessary distinctions between the process of notification and the linkage of HIV-positive individuals to care. **Please refer to table above for a description of activities essential to**

**informing individuals of their HIV status by subpopulation, including information on which essential activities are to be implemented immediately and which activities are proposed but are NOT able to be implemented immediately.**

ii) **Coordination with Ryan White Part B:** Although not required by HRSA, in San Francisco, the HIV Health Services Planning Council is charged with coordinating Part A and B and services to maximize the impact of both funding streams. This service planning process is in turn coordinated with all units of the San Francisco AIDS Office, including the HIV Prevention Section, in order to enhance regional efforts to identify and link to care persons with HIV who are unaware of their positive status.

iii) **Coordination with Prevention and Disease Control Programs:** As noted above, the San Francisco EMA's integrated HIV testing, referral, and linkage program involves intensive collaborations with all sectors of the region's health, prevention, and social service communities. In relation to informing persons of their HIV status, for example, the San Francisco Department of Health provides ongoing training and technical assistance services to encourage agencies to adopt standardized opt-out testing protocols, in part by overcoming fears regarding how staff are to inform patients of a positive HIV test result. By sharing protocols and best practices regarding the informing process, and by providing prompt and immediate linkage to PHAST Team members, DPH can encourage greater promulgation of routinized HIV testing across the EMA.

### 2.b.3.c) Referring to Medical Care and Services

i) **Essential Activities to Refer Individuals to Medical Care and Services:** Because of the importance of ensuring that newly identified HIV-positive persons enter care, San Francisco has consistently prioritized active linkage, which includes ongoing support and verification of care entry, over passive referral. This commitment has grown stronger over the past decade, as the EMA has begun to see the positive public health implications of communitywide viral load suppression. The EMA has also developed effective systems for making **immediate** linkages to care at the time of HIV test disclosure, including through co-location of testing and care services and through the use of peer and bridge personnel to schedule appointments and accompany clients to care and treatment venues. **In its 2010 HIV Prevention Plan, the San Francisco HIV Prevention Section does away with the step of "referring individuals to HIV care" entirely, and places linkage to service immediately following disclosure of test results in its required steps for both rapid and conventional testing approaches.**

Although the EMA emphasizes effective service linkages, limited resources prevent using the linkage approach to address all client needs. Primary care access is always facilitated through linkage. Access to ancillary services is facilitated through linkage and co-location of services but is sometimes done through referral. The EMA consistently ensures that all HIV testing providers and venues have access to comprehensive resource directories regarding all available HIV care and service programs in the EMA, cross-referenced for specific subpopulations such as MSM, active substance users, transgender persons, and persons who speak a primary language other than English. These directories are used to make targeted client referrals that are tailored to the needs of those testing positive. At the same time, through extensive collaborative networks throughout the EMA, many providers maintain referral relationships that facilitate client access to care, including, for example, relationships between non-HIV-specific testing sites and HIV specialist care and treatment agencies. **Please refer to table above for a description of activities essential to informing individuals of their HIV status by subpopulation, including information on which essential activities are to be implemented immediately and which activities are proposed but are NOT able to be implemented immediately.**

OFFICE OF THE MAYOR
SAN FRANCISCO

EDWIN M. LEE
MAYOR

TO: Angela Calvillo, Clerk of the Board of Supervisors

FROM: Mayor Edwin M. Lee

RE: Approval of the Ryan White Act HIV/AIDS Emergency Relief Grant Program application - $36,118,233

DATE: September 25, 2012

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Attached for introduction to the Board of Supervisors is the resolution authorizing the San Francisco Department of Public Health to submit an application to continue to receive funding for the Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A) grant from the Health Resources Services Administration, requesting $36,118,233 in HIV emergency relief program funding for the San Francisco Eligible Metropolitan Area for the period of March 1, 2013, through February 28, 2014.

Please note this item is cosponsored by Supervisor Wiener.

I request that this item be referred for adoption without committee reference.

Should you have any questions, please contact Jason Elliott (415) 554-5105.

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cc. Supervisor Scott Wiener

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