File No. 121074 Committee Item No. 5
Board Item No. 31

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget and Finance Committee **Date** 11/14/2012

Board of Supervisors Meeting **Date** November 20, 2012

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Completed by: Victor Young **Date** November 9, 2012
Completed by: Victor Young **Date** 11-15-12

[Accept and Expend Grant - Special Projects of National Significance Program - $300,000]

Resolution authorizing the San Francisco Department of Public Health to retroactively accept and expend a grant in the amount of $300,000 from the Health Resources and Services Administration to participate in a program entitled "Special Projects of National Significance Program Building a Medical Home for Multiply Diagnosed HIV Positive Homeless Populations - Demonstration Sites" for the period of September 1, 2012, through August 31, 2013, and waiving indirect costs.

WHEREAS, Health Resources and Services Administration (HRSA) has agreed to fund San Francisco Department of Public Health (SFDPH) in the amount of $300,00 for the period of September 1, 2012, through August 31, 2013; and

WHEREAS, The full project period of the grant starts on September 1, 2012 and ends on August 31, 2017, with years two, three, four and five subject to availability of funds and satisfactory progress of the project; and

WHEREAS, As a condition of receiving the grant funds, HRSA requires the City to enter into an agreement (the "Agreement"), a copy of which is on file with the Clerk of the Board of Supervisors in File No. 121074; which is hereby declared to be a part of this resolution as if set forth fully herein; and

WHEREAS, The purpose of this project is to develop and implement the HIV Homeless Outreach Mobile Engagement project-a mobile, multidisciplinary team-based intervention specifically designed to engage and retain in care the most severely impacted and hardest-to-serve homeless persons living with HIV in San Francisco; and

WHEREAS, DPH will subcontract with Asian and Pacific Islander Wellness Center in the total amount of $184,995; for the period of September 1, 2012, through August 31, 2013; and

WHEREAS, An Annual Salary Ordinance amendment is not required as the grant partially reimburses DPH for two existing positions, one Registered Nurse (Job Class No. 2320) at .20 FTE and one Health Worker II (Job Class No. 2586) at 1.0 FTE for the period of September 1, 2012, through August 31, 2013; and

WHEREAS, A request for retroactive approval is being sought because DPH did not receive notification of the award until August 28, 2012 for a project start date of September 1, 2012; and

WHEREAS, Special Projects of National Significance Program Building a Medical Home for Multiply Diagnosed HIV Positive Homeless Populations – Demonstration Sites grant does not allow for indirect costs to maximize use of grant funds on direct services; and

WHEREAS, The grant terms prohibit including indirect costs in the grant budget; now, therefore, be it

RESOLVED, That DPH is hereby authorized to accept and expend a grant retroactively in the amount of $300,000 from HRSA; and, be it

FURTHER RESOLVED, That the Board of Supervisors hereby waives inclusion of indirect costs in the grant budget; and, be it

FURTHER RESOLVED, That DPH is hereby authorized to retroactively accept and expend the grant funds pursuant to San Francisco Administrative Code section 10.170-1; and, be it

FURTHER RESOLVED, That the Director of Health is authorized to enter into the agreement on behalf of the City.

RECOMMENDED:

for

Barbara A. Garcia, MPA
Director of Health

APPROVED:

Office of the Mayor

Office of the Controller

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
SPNS BUILDING A MEDICAL HOME FOR MULTIPLY DIAGNOSED HIV POSITIVE HOMELESS POPULATIONS - DEMONSTRATION SITES
SECOND YEAR PROJECT BUDGET
SEPTEMBER 1, 2013 - AUGUST 31, 2014

		Annual	FTE	Total
A.	**PERSONNEL**			
	1. In-Kind Principal Investigator - (Deborah Borne, MD) -		0.05	$0
	2. Registered Nurse - (TBA) -	123,000	0.20	24,600
	3. Health Worker II (Outreach Worker) - (TBA) -	49,250	1.00	49,250
	Subtotal, Personnel			**$73,850**
B.	**FRINGE BENEFITS @ 30% of Salaries -**			**$22,155**
	Total Personnel			**$96,005**
C.	**TRAVEL**			
	1. Required Grant Conference Travel - 2 SPNS Conferences Per Year x 2 Participants @ $1,000 Per Trip =			**$4,000**
D.	**EQUIPMENT - None**			
E.	**SUPPLIES - None**			
F.	**CONTRACTUAL**			
	1. Asian & Pacific Islander Wellness Center -			**$184,995**
G.	**CONSTRUCTION - None**			
H.	**OTHER - None**			
	1. Two (2) Dedicated Stabilization Rooms @ $7,500 Per Year =			**$15,000**
H.	**TOTAL DIRECT CHARGES**			**$300,000**
I.	**INDIRECT CHARGES - None**			**$0**
J.	**TOTAL SECOND YEAR PROJECT BUDGET**			**$300,000**

ASIAN & PACIFIC ISLANDER WELLNESS CENTER
SECOND YEAR SUBCONTRACT BUDGET

		Annual Salary	FTE	Total Amount
A.	**PERSONNEL**			
	1. Project Dir. / Evaluation Coordinator / MSW - (TBA) -	$60,000	1.00	$60,000
	2. Medical Social Worker - (TBA) -	55,000	0.75	41,250
	3. Homeless Peer Navigator - (TBA) -	32,104	1.00	32,104
	Subtotal			**$133,354**
	Fringe Benefits @ 25% of Salaries -			**$33,339**
	Total Personnel			**$166,693**
C.	**TRAVEL**			
	1. Local Mileage / Transportation - Avg. $45 Per Month Per FTE x 2.75 FTE x 12 Months =			**$1,485**
H.	**TOTAL DIRECT CHARGES**			**$168,178**
I.	**INDIRECT CHARGES @ 10% =**			**$16,818**
J.	**TOTAL SECOND YEAR SUBCONTRACT BUDGET**			**$184,995**

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
SPNS BUILDING A MEDICAL HOME FOR MULTIPLY DIAGNOSED HIV POSITIVE HOMELESS POPULATIONS - DEMONSTRATION SITES
THIRD YEAR PROJECT BUDGET
SEPTEMBER 1, 2014 - AUGUST 31, 2015

		Annual	FTE	Total
A.	**PERSONNEL**			
	1. In-Kind Principal Investigator - (Deborah Borne, MD) -		0.05	$0
	2. Registered Nurse - (TBA) -	123,000	0.20	24,600
	3. Health Worker II (Outreach Worker) - (TBA) -	49,250	1.00	49,250
	Subtotal, Personnel			**$73,850**
B.	**FRINGE BENEFITS @ 30% of Salaries -**			**$22,155**
	Total Personnel			**$96,005**
C.	**TRAVEL**			
	1. Required Grant Conference Travel - 2 SPNS Conferences Per Year x 2 Participants @ $1,000 Per Trip =			**$4,000**
D.	**EQUIPMENT - None**			
E.	**SUPPLIES - None**			
F.	**CONTRACTUAL**			
	1. Asian & Pacific Islander Wellness Center -			**$184,995**
G.	**CONSTRUCTION - None**			
H.	**OTHER - None**			
	1. Two (2) Dedicated Stabilization Rooms @ $7,500 Per Year =			**$15,000**
H.	**TOTAL DIRECT CHARGES**			**$300,000**
I.	**INDIRECT CHARGES - None**			**$0**
J.	**TOTAL THIRD YEAR PROJECT BUDGET**			**$300,000**

ASIAN & PACIFIC ISLANDER WELLNESS CENTER
THIRD YEAR SUBCONTRACT BUDGET

		Annual Salary	FTE	Total Amount
A.	**PERSONNEL**			
	1. Project Dir. / Evaluation Coordinator / MSW - (TBA) -	$60,000	1.00	$60,000
	2. Medical Social Worker - (TBA) -	55,000	0.75	41,250
	3. Homeless Peer Navigator - (TBA) -	32,104	1.00	32,104
	Subtotal			**$133,354**
	Fringe Benefits @ 25% of Salaries -			**$33,339**
	Total Personnel			**$166,693**
C.	**TRAVEL**			
	1. Local Mileage / Transportation - Avg. $45 Per Month Per FTE x 2.75 FTE x 12 Months =			**$1,485**
H.	**TOTAL DIRECT CHARGES**			**$168,178**
I.	**INDIRECT CHARGES @ 10% =**			**$16,818**
J.	**TOTAL THIRD YEAR SUBCONTRACT BUDGET**			**$184,995**

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
SPNS BUILDING A MEDICAL HOME FOR MULTIPLY DIAGNOSED HIV POSITIVE HOMELESS POPULATIONS - DEMONSTRATION SITES
FOURTH YEAR PROJECT BUDGET
SEPTEMBER 1, 2015 - AUGUST 31, 2016

		Annual	FTE	Total
A.	**PERSONNEL**			
	1. In-Kind Principal Investigator - (Deborah Borne, MD) -		0.05	$0
	2. Registered Nurse - (TBA) -	123,000	0.20	24,600
	3. Health Worker II (Outreach Worker) - (TBA) -	49,250	1.00	49,250
	Subtotal, Personnel			**$73,850**
B.	**FRINGE BENEFITS @ 30% of Salaries -**			**$22,155**
	Total Personnel			**$96,005**
C.	**TRAVEL**			
	1. Required Grant Conference Travel - 2 SPNS Conferences Per Year x 2 Participants @ $1,000 Per Trip =			**$4,000**
D.	**EQUIPMENT - None**			
E.	**SUPPLIES - None**			
F.	**CONTRACTUAL**			
	1. Asian & Pacific Islander Wellness Center -			**$184,995**
G.	**CONSTRUCTION - None**			
H.	**OTHER - None**			
	1. Two (2) Dedicated Stabilization Rooms @ $7,500 Per Year =			**$15,000**
H.	**TOTAL DIRECT CHARGES**			**$300,000**
I.	**INDIRECT CHARGES - None**			**$0**
J.	**TOTAL FOURTH YEAR PROJECT BUDGET**			**$300,000**

ASIAN & PACIFIC ISLANDER WELLNESS CENTER
FOURTH YEAR SUBCONTRACT BUDGET

		Annual Salary	FTE	Total Amount
A.	**PERSONNEL**			
	1. Project Dir. / Evaluation Coordinator / MSW - (TBA) -	$60,000	1.00	$60,000
	2. Medical Social Worker - (TBA) -	55,000	0.75	41,250
	3. Homeless Peer Navigator - (TBA) -	32,104	1.00	32,104
	Subtotal			**$133,354**
	Fringe Benefits @ 25% of Salaries -			**$33,339**
	Total Personnel			**$166,693**
C.	**TRAVEL**			
	1. Local Mileage / Transportation - Avg. $45 Per Month Per FTE x 2.75 FTE x 12 Months =			**$1,485**
H.	**TOTAL DIRECT CHARGES**			**$168,178**
I.	**INDIRECT CHARGES @ 10% =**			**$16,818**
J.	**TOTAL FOURTH YEAR SUBCONTRACT BUDGET**			**$184,995**

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
SPNS BUILDING A MEDICAL HOME FOR MULTIPLY DIAGNOSED HIV POSITIVE HOMELESS POPULATIONS - DEMONSTRATION SITES
FIFTH YEAR PROJECT BUDGET
SEPTEMBER 1, 2016 - AUGUST 31, 2017

		Annual	FTE	Total
A.	**PERSONNEL**			
	1. In-Kind Principal Investigator - (Deborah Borne, MD) -		0.05	$0
	2. Registered Nurse - (TBA) -	123,000	0.20	24,600
	3. Health Worker II (Outreach Worker) - (TBA) -	49,250	1.00	49,250
	Subtotal, Personnel			**$73,850**
B.	**FRINGE BENEFITS @ 30% of Salaries -**			**$22,155**
	Total Personnel			**$96,005**
C.	**TRAVEL**			
	1. Required Grant Conference Travel - 2 SPNS Conferences Per Year x 2 Participants @ $1,000 Per Trip =			**$4,000**
D.	**EQUIPMENT - None**			
E.	**SUPPLIES - None**			
F.	**CONTRACTUAL**			
	1. Asian & Pacific Islander Wellness Center -			**$184,995**
G.	**CONSTRUCTION - None**			
H.	**OTHER - None**			
	1. Two (2) Dedicated Stabilization Rooms @ $7,500 Per Year =			**$15,000**
H.	**TOTAL DIRECT CHARGES**			**$300,000**
I.	**INDIRECT CHARGES - None**			**$0**
J.	**TOTAL FIFTH YEAR PROJECT BUDGET**			**$300,000**

ASIAN & PACIFIC ISLANDER WELLNESS CENTER
FIFTH YEAR SUBCONTRACT BUDGET

		Annual Salary	FTE	Total Amount
A.	**PERSONNEL**			
	1. Project Dir. / Evaluation Coordinator / MSW - (TBA) -	$60,000	1.00	$60,000
	2. Medical Social Worker - (TBA) -	55,000	0.75	41,250
	3. Homeless Peer Navigator - (TBA) -	32,104	1.00	32,104
	Subtotal			**$133,354**
	Fringe Benefits @ 25% of Salaries -			**$33,339**
	Total Personnel			**$166,693**
C.	**TRAVEL**			
	1. Local Mileage / Transportation - Avg. $45 Per Month Per FTE x 2.75 FTE x 12 Months =			**$1,485**
H.	**TOTAL DIRECT CHARGES**			**$168,178**
I.	**INDIRECT CHARGES @ 10% =**			**$16,818**
J.	**TOTAL FIFTH YEAR SUBCONTRACT BUDGET**			**$184,995**

File Number: _____
(Provided by Clerk of Board of Supervisors)

Grant Resolution Information Form
(Effective July 2011)

Purpose: Accompanies proposed Board of Supervisors resolutions authorizing a Department to accept and expend grant funds.

The following describes the grant referred to in the accompanying resolution:

1. Grant Title: **Special Projects of National Significance Program Building a Medical Home for Multiply Diagnosed HIV Positive Homeless Populations – Demonstration Sites**

2. Department: **Department of Public Health**
Community Health Services
Community Oriented Primary Care

3. Contact Person: **Dean Goodwin** Telephone: **415-554-9054**

4. Grant Approval Status (check one):

[X] Approved by funding agency [ ] Not yet approved

5. Amount of Grant Funding Approved or Applied for: **$1,500,000 in the 5-year project period**
(Year 1 = $300,000; Year 2 = $300,000; Year 3 = $300,000; Year 4 = $300,000; Year 5 = $300,000)

6a. Matching Funds Required: **$0**
b. Source(s) of matching funds (if applicable):

7a. Grant Source Agency: Health Resources and Services Administration
b. Grant Pass-Through Agency (if applicable):

8. Proposed Grant Project Summary: **To develop and implement the HIV Homeless Outreach Mobile Engagement (HOME) project-a mobile, multidisciplinary team-based intervention specifically designed to engage and retain in care the most severely impacted and hardest-to-serve homeless persons living with HIV in San Francisco.**

9. Grant Project Schedule, as allowed in approval documents, or as proposed:

Approved Year one project: **Start-Date: 09/01/2012** **End-Date: 08/31/2013**
Full project period: **Start-Date: 09/01/2012** **End-Date: 08/31/2017**

10a. Amount budgeted for contractual services: **$184,995 in Year 1**
$924,975 in the 5-year project period

b. Will contractual services be put out to bid? **No**

c. If so, will contract services help to further the goals of the Department's Local Business Enterprise (LBE) requirements? **N/A**

d. Is this likely to be a one-time or ongoing request for contracting out? **N/A**

11a. Does the budget include indirect costs? [] Yes [X] No

b1. If yes, how much? **$0**
b2. How was the amount calculated?

c1. If no, why are indirect costs not included?

[ ] Not allowed by granting agency
[ ] Other (please explain):

[X] To maximize use of grant funds on direct services

c2. If no indirect costs are included, what would have been the indirect costs?
$78,630 (26.21% of total direct costs)

12. Any other significant grant requirements or comments:

We respectfully request for approval to accept and expend these funds retroactive to September 01, 2012. The Department received the subaward agreement on August 28, 2012.

Grant Code: **HCAO62/1200**

****Disability Access Checklist***(Department must forward a copy of all completed Grant Information Forms to the Mayor's Office of Disability)**

13. This Grant is intended for activities at (check all that apply):

[X] Existing Site(s)
[ ] Rehabilitated Site(s)
[ ] New Site(s)

[ ] Existing Structure(s)
[ ] Rehabilitated Structure(s)
[ ] New Structure(s)

[ ] Existing Program(s) or Service(s)
[ ] New Program(s) or Service(s)

14. The Departmental ADA Coordinator or the Mayor's Office on Disability have reviewed the proposal and concluded that the project as proposed will be in compliance with the Americans with Disabilities Act and all other Federal, State and local disability rights laws and regulations and will allow the full inclusion of persons with disabilities. These requirements include, but are not limited to:

1. Having staff trained in how to provide reasonable modifications in policies, practices and procedures;
2. Having auxiliary aids and services available in a timely manner in order to ensure communication access;
3. Ensuring that any service areas and related facilities open to the public are architecturally accessible and have been inspected and approved by the DPW Access Compliance Officer or the Mayor's Office on Disability Compliance Officers.

If such access would be technically infeasible, this is described in the comments section below:

Comments:

Departmental ADA Coordinator or Mayor's Office of Disability Reviewer:

Jason Hashimoto
(Name)

Director, EEO, and Cultural Competency Programs
(Title)

Date Reviewed: 10/10/12

for
(Signature Required)

Department Head or Designee Approval of Grant Information Form:

Barbara A. Garcia, MPA
(Name)

Director of Health
(Title)

Date Reviewed: 10/10/12

for
(Signature Required)

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
SPNS BUILDING A MEDICAL HOME FOR MULTIPLY DIAGNOSED HIV POSITIVE HOMELESS POPULATIONS - DEMONSTRATION SITES
FIRST YEAR PROJECT BUDGET
SEPTEMBER 1, 2012 - AUGUST 31, 2013

		Annual	FTE	Total
A.	**PERSONNEL**			
1.	In-Kind Principal Investigator - (Deborah Borne, MD) -		0.05	$0
2.	Registered Nurse - (TBA) -	123,000	0.20	24,600
3.	Health Worker II (Outreach Worker) - (TBA) -	49,250	1.00	49,250
	Subtotal, Personnel			$73,850
B.	**FRINGE BENEFITS @ 30% of Salaries -**			$22,155
	Total Personnel			$96,005
C.	**TRAVEL**			
1.	Required Grant Conference Travel - 2 SPNS Conferences Per Year x 2 Participants @ $1,000 Per Trip =			$4,000
D.	**EQUIPMENT - None**			
E.	**SUPPLIES - None**			
F.	**CONTRACTUAL**			
1.	Asian & Pacific Islander Wellness Center -			$184,995
G.	**CONSTRUCTION - None**			
H.	**OTHER - None**			
1.	Two (2) Dedicated Stabilization Rooms @ $7,500 Per Year =			$15,000
H.	**TOTAL DIRECT CHARGES**			$300,000
I.	**INDIRECT CHARGES - None**			$0
J.	**TOTAL FIRST YEAR PROJECT BUDGET**			$300,000

ASIAN & PACIFIC ISLANDER WELLNESS CENTER
FIRST YEAR SUBCONTRACT BUDGET

		Annual Salary	FTE	Total Amount
A.	**PERSONNEL**			
1.	Project Dir. / Evaluation Coordinator / MSW - (TBA) -	$60,000	1.00	$60,000
2.	Medical Social Worker - (TBA) -	55,000	0.75	41,250
3.	Homeless Peer Navigator - (TBA) -	32,104	1.00	32,104
	Subtotal			$133,354
	Fringe Benefits @ 25% of Salaries -			$33,339
	Total Personnel			$166,693
C.	**TRAVEL**			
1.	Local Mileage / Transportation - Avg. $45 Per Month Per FTE x 2.75 FTE x 12 Months =			$1,485
H.	**TOTAL DIRECT CHARGES**			$168,178
I.	**INDIRECT CHARGES @ 10% =**			$16,818
J.	**TOTAL FIRST YEAR SUBCONTRACT BUDGET**			$184,995

San Francisco Department of Health Services
The HOME Project: Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations - Demonstration Sites
SPNS FOA # HRSA-12-100

Year 1 Budget Justification

September 1, 2012 - August 31, 2013

Personnel - $73,850

1. In-Kind Principal Investigator (Deborah Borne, MD) - $0
The in-kind Principal Investigator will be responsible for ensuring the overall quality, consistency, impact, and effectiveness of the HOME Project. The PI will develop and oversee project subcontracts; convene meetings of the Project Management Team; serve as administrative program contact to HRSA; ensure coordination and integration of the initiative within the San Francisco Department of Public Health as a whole; and maximize the use of complementary resources to add value and impact to the proposed initiative. The PI will collaborate with project management and HRSA staff to develop and implement an internal evaluation plan for the HOME Project, including developing effective data collection, storage, tracking, extraction, and analysis systems to ensure protected and accessible project data. The PI will also work closely with the Evaluation and Technical Assistance Center (ETAC) to develop and produce data for the national cross-site evaluation and will continually monitor data quality and data collection procedures.

2. Registered Nurse (TBA)- $123,000/Yr. x 0.2 FTE = $24,600
In collaboration with a primary care physician, the Registered Nurse will provide field-based psychiatric nursing care to homeless individuals with HIV; provide patient care in a non-discriminatory and non-judgmental manner; perform triage and nursing assessments; perform health maintenance assessments and interventions, including immunizations, TB screening, medication administration, and wound care; develop and implement nursing care plans; provide patient education; and arrange follow-up care.

3. Health Worker II (TBA)- $49,250/Yr. x 1.0 FTE = $49,250
The Health Worker II will be responsible for establishing initial contact with new project clients and for ensuring that the multidisciplinary team maintains contact with those clients throughout the course of the project. The Health Worker II will also ensure coordination with outreach programs of the SF HOT program, including ensuring that clients do not receive duplicated case management. The Health Worker II will develop caring, one-on-one relationships with homeless individuals to help anchor and retain them in care; maintain ongoing contact with clients in order to continually monitor their location and life circumstances; and track down and re-engage clients who become temporarily lost to the team.

Fringe Benefits: Includes health insurance, FICA, other costs and benefits at 30.0% = $22,155

Travel - $4,000

1. Required Grant Conference Travel - 2 SPNS Conferences Per Year x 2 Participants Per Conference@ $1,000 Per Trip= $4,000
The above line item covers the cost of two SPNS project staff attending two required SPNS conferences during the first project year in Washington, DC. The breakdown of the average cost per trip is as follows:

Plane Fare- $525
Hotel Stay- 2 Nights @ $175 Per Night= $350
Per Diem- 3 Days@ $75 Per Day= $125

Total Cost Per Trip - $1,000

Contractual- $184,995

1. Asian & Pacific Islander Wellness Center- $184,995
As the primary project partner for the HOME Project, the highly respected non-profit organization Asian & Pacific Islander Wellness Center will utilize subcontract funds to hire and provide a home base for three key project staff members, consisting of the following:

- Personnel - $133,354

1. Project Director / Evaluation Coordinator / Medical Social Worker (TBA)- $60,000/Yr. x 1.0 FTE = $60,000
In the role of Project Director, this individual will provide day-to-day oversight, supervision, and coordination of the HOME Project and will serve as day-to-day project contact with HRSA SPNS staff. The Director will be responsible for supervising and supporting project staff; organizing project timelines and calendars; and convening and leading staff meetings. As Evaluation Coordinator, this individual will ensure the ongoing timeliness and accuracy of project data collection and will play a key role in data analysis and reporting, including preparing regular project reports. As Medical Social Worker, this individual will conduct field-based assessments of homeless client needs, including conducting psychosocial and cognitive assessments; develop and continually update collaborative client care plans; provide referrals to health and psychosocial service resources and programs; and provide informal, field-based short-term psychosocial counseling to address immediate client barriers and impediments to care, including mental health and substance abuse issues

2. Medical Social Worker (TBA)- $55,000/Yr. x .75 FTE = $41,250
As above, the second Medical Social Worker will conduct field-based assessments of homeless client needs, including conducting psychosocial and cognitive assessments; develop and continually update collaborative client care plans; provide referrals to health and psychosocial service resources and programs; and provide informal, field-based short-term psychosocial counseling to address immediate client barriers and impediments to care, including mental health and substance abuse issues

3. Homeless Peer Navigator- (TBA) -$32,104/Yr. x 1.00 FTE = $32,104
   The Homeless Peer Navigator will play a critical team role in the project by directly linking clients to care and continually supporting them in accessing essential project services. The Navigator will provide referrals and linkage support to essential identified health, behavioral, and psychosocial resources, including housing, employment, mental health, substance abuse, and domestic violence services and will accompany clients to appointments and service agencies as needed. The Navigator will also provide client advocacy as needed to help client access services to help them remain in HIV care and treatment

   Fringe Benefits @ 25% = $33,339

- Travel- $1,485

  1. Local Mileage & Transportation- Avg. $45 Per Month Per FTE
     x 2.75 FTE x 12 Months= $1,485
     The above line item supports the cost of mobile team members traveling throughout San Francisco to provide field based care coordination and support and to link clients to key service appointments and venues.

Other- $15,000

1. Two (2) Dedicated Stabilization Rooms @ $7,500 Per Year x 2 = $15,000
The two dedicated short-teml stabilization rooms will provide immediate access to housing while clients work to stabilize the conditions of their lives. The rooms will provide a temporary bridge to housing for patients who are becoming more able to consider a long-term housing option.

There are no changes at this time between the budget proposed for program year one (09/1/12 - 8/31/13) and the budgets proposed for programs years two through five (09/1/13 - 8/31/17).

San Francisco Department of Health Services
The HOME Project: Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations - Demonstration Sites
SPNS FOA # HRSA-12-100

"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

INTRODUCTION

As the city with the highest per capita rate of HIV infection and the second highest rate of homelessness in the United States, San Francisco has been extremely hard hit by the dual crises of homelessness and HIV. As noted in the needs assessment below, homeless persons with HIV face significant barriers to care entry and retention, including high rates of mental illness and substance abuse. In response to this crisis - and in keeping with the city's longstanding tradition of striving to ensure equitable care for all San Franciscans - the city has developed a **multi-leveled system of integrated care for homeless and marginally housed HIV-positive populations**. This system, incorporating medical care, case management, behavioral health support, dental care, peer navigation, access to stabilization and permanent housing, expanded public insurance programs, and computerized patient registries, has become a national model for the provision of supportive care for homeless persons with HIV. The system has also proven to be highly successful, engaging and retaining in care roughly **75% - 80%** of the city's HIV-infected homeless population - a remarkable success record given the large number of homeless persons who continue to migrate to the city each year.

But for the remaining **20% - 25%** of San Francisco's HIV-infected homeless - a population living with multiple co-morbidities including severe and persistent mental illness, active substance use, and chronic illnesses apart from HIV - the problem of HIV care utilization and treatment adherence has proven to be more intractable. These individuals are highly transient; lack the psychological and behavioral stability to access care through traditional medical facilities; and are often difficult to retain short or long-term housing as a result of behavioral issues. Providing HIV specialist care and ensuring that these individuals adhere to HIV medication regimens is an extremely daunting task, especially given the difficulties involved in managing mental health issues and in tracking these individuals' location from day to day. At the same time, however, it is vitally important to engage and retain this hardest-to-reach population in HIV care, in part because of the high level of risk behaviors in which they engage and in part because of high utilization of emergency and urgent care resources to address avoidable health conditions.

The San Francisco Department of Public Health's (SFDPH) Community Oriented Primary Care Program requests FY 2012 Ryan White Special Projects of National Significance (SPNS) funding to develop and implement the **HIV Homeless Outreach Mobile Engagement (HOME) Project** - a mobile, multidisciplinary team-based intervention specifically designed to engage and retain in care the most severely impacted and hardest-to-serve homeless persons living with HIV in San Francisco. The HOME Project will differ from prior mobile team models in that it will explicitly target those homeless individuals who are the **most difficult to engage and retain**

in care - individuals facing complex, multiple co-morbidities and barriers who have thus far resisted attempts to engage them in housing and/or HIV treatment. These hardest-to-serve individuals exist in virtually every major urban area. However, in most cases, limited local resources force jurisdictions to focus on their **entire** local homeless HIV population, leaving these individuals to fend for themselves. San Francisco's existing system of interdisciplinary homeless health care - a system that relies on extensive existing partnerships with virtually all aspects of the local health and housing system - offers a unique opportunity to build on our unparalleled resources to test a **more focused** model of cost-effective mobile HIV care that is exclusively directed to those homeless HIV-infected individuals in every city who are nearly always the ones **left behind** by broader homeless HIV interventions and programs. The SPNS model will be tested, evaluated, and refined throughout the course of the grant program and can in turn be replicated in other urban regions, in whole or in part, following the conclusion of the grant period.

NEEDS ASSESSMENT

The burden of HIV/AIDS among homeless populations in the United States is well documented[2]. Homeless persons can generally encompass those living on the streets, in abandoned buildings, in shelters, in any space not designated for shelter, as well as those living in unstable conditions such as people temporarily staying with friends or family, multiple persons in one room, people without a permanent address, and people in a room or apartment who lack the financial stability to continue to pay for housing and who face eviction because of behavioral health issues. Chronic homelessness can be defined as homelessness among people who have disabilities, including serious mental illness, chronic substance use disorders, or chronic medical issues, and who are homeless repeatedly or for long periods of time[3]. According to Homeless Research Institute, from 2008 to 2009, conditions worsened nationally among all four economic indicators of future homelessness, including housing affordability for poor people, unemployment (which increased by 60 percent during this period), poor workers' income, and foreclosure status[4].

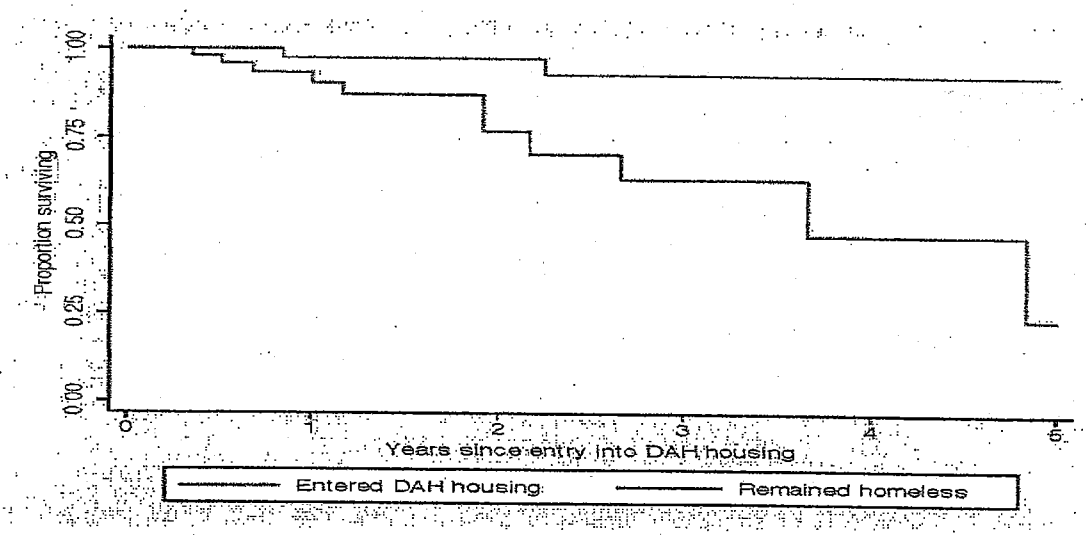
Health and homelessness are deeply interwoven with increased rates of chronic illness such as including HIV/AIDS, which is more prevalent in the homeless population[5], due in part to the effects of lifestyle factors such as drug, alcohol, or tobacco use, exposure to extreme weather, nutritional deficiencies, and violence[6]. The basic needs of homeless PWLH, including food clothing and shelter, often supersede considerations regarding routine HIV medical care[7]. Moreover, given that homelessness is nearly always associated with poverty, a lack of access to free medical care can serve as a further barrier to HIV therapy. As a result, homelessness is associated with increased mortality in HIV-infected persons[8]. In San Francisco homelessness is an ongoing crisis, 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. Because of their disconnection from health and social services, homeless individuals are the population **least likely** to obtain regular health or preventative care.

Housing status is a key structural factor affecting access to treatment and health behaviors among people living with HIV/AIDS[9]. Research shows that housing assistance is associated over time with reduced HIV risk behaviors and improved health care outcomes, controlling for a wide range of individual characteristics (poverty, race/ethnicity, substance abuse, mental illness) and

service use variables (primary care, case management, substance abuse, and mental health treatment). Housing assistance coupled with health care has been shown to decrease overall public expenses and to make better use of limited public resources[10]. Without stable housing, persons with HIV experience difficulties in accessing primary medical care, adhering to HIV treatments, and sustaining overall health and wellbeing. Individuals who are homeless also lack adequate transportation, lack awareness of services and resources, and have poor provider attitudes. One Health Care for the Homeless survey found that many individuals are excluded from primary care, specialty care, respite care, and case management because they are homeless[11]. Homelessness is also associated with significantly higher rates of emergency room admissions and more frequent and longer inpatient hospitalization encounters[12] with the burden of HIV disease complicating this problem. Frequent emergency care admissions and long inpatient stays are both costly and burdensome for public health systems and in cities throughout the US the public cost of emergency care and hospitalization admissions are among the most significant expenses associated with homelessness.

In addition to these factors, local research has demonstrated that stable supportive housing in itself dramatically reduces both morbidity and mortality among homeless persons living with HIV and AIDS. A recent San Francisco study led by Dr. Sandra Schwartz of the San Francisco Department of Public Health utilized data from the department's AIDS Case Registry and found that a total of **683** people in San Francisco were homeless at the time of their AIDS diagnosis. Of these, **73** were housed in supportive facilities through the County's Direct Access to Housing (DAH) program. The study matched **45** people housed in DAH facilities with **45** people who had similar CD4 counts, Viral load levels, ethnicity, substance abuse, age, and gender who were not housed in DAH. As the K-M curve below shows (see **Figure 1**), among the people with HIV **not** housed in DAH **only 25% were alive after 5 years**. By contrast, among the PLWH who were housed in DAH supportive housing, **only 2 people had died after 5 years**. This represents a staggering **80% reduction in mortality** as a result of simply residing in supportive housing facilities.[13]

Figure 1. Comparison of Mortality Rates Among Persons with HIV Housed and Not Housed in DAH Supportive Housing Programs



Homelessness in San Francisco has a distinct and well-established link to HIV/AIDS. It is estimated that at least **3.2%** of the 3.5 million homeless in the U.S. are HIV-positive compared to just **0.4%** of adults and adolescents in the general population [14]. In San Francisco, estimations of HIV prevalence among homeless persons have been more than double (**6.5%**) this average . and more than **six times** the average of the general US population . At least **1,605** HIV-infected homeless individuals are estimated to be living in the San Francisco EMA (based on an estimated**7%** homelessness rate among PLWH) and at least **25%** of those who are aware of their HIV status are estimated to be out of care. San Francisco also has the dubious distinction of having second highest per capita homeless rate in the country[15] and the number of homeless HIV cases in San Francisco continues to increase. Homeless persons now account for **9% to 13%** of all HIV diagnoses. Among marginally housed MSM, the prevalence rate increases to **41%**. For persons diagnosed with HIV in San Francisco in 2010, **13%** were homeless at the time of diagnosis[16]. The local; homeless population also has a significantly lower rate of ART use among both those with an AIDS diagnosis (**82%**) and those with an HIV diagnosis (**44%**). A recent study by the University of California San Francisco also found that the City's chronic homeless population has 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.[17] 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.

Because of their disconnection from health and social service systems, homeless individuals are the population **least likely** to obtain regular health or preventive care. Factors such as poor hygiene, malnutrition, and exposure to the elements render the homeless vulnerable to illness at a rate **three to six-times** that of the housed[18]. Additionally, a crowded shelter system in San Francisco exposes homeless PWLH to infections such as hepatitis A, pneumonia, tuberculosis, and various skin infections. One report shows that HIV-infected people who sleep in shelters are **twice as likely** to have tuberculosis[19]. Homelessness also acts as a critical HIV infection risk factor in itself, with an estimated **69%** of homeless engaging in one or more HIV risk factors[20]. Homeless PWLH have lower CD4 counts, are less likely to take HIV anti-retroviral medications, and are less adherent to medication regimens and need dramatically increased HIV social and medical services. In addition, as noted above, housing status continues to be a significant predictor of health and medication outcomes[21].

Antiretroviral initiation and adherence in homeless PWLH is complex and difficult to predict. Despite the fact that medical indications for initiating treatment are the same for PWLH who are not homeless, factors such as provider reluctance, the lack of a safe place to store medications, and concomitant alcohol, drug, and mental health problems can affect the feasibility and timing of treatment initiation[22]. Following treatment initiation, factors such as depression, injection drug use, and African-American ethnicity, among others, have been identified as significant predictors for discontinuing treatment[23].

Although homelessness affects people of all ages, races, ethnicities, and geographies, there are groups that are at markedly increased risk of homelessness. In Los Angeles, one study found that **53%** of domiciled PWLH felt they were at the risk for becoming homeless[24]. In Philadelphia, **44%** of PWLH were unable to afford their housing[25]. Of the nearly 12,000 PWLH surveyed by AIDS Housing of Washington, **40%** reported being homeless at least once during the course of their infection[26]. As noted above, HIV/AIDS coupled with housing marginalization

also leads to an inability to meet basic needs such as food, clothing, medication adherence, and health maintenance[27].

The problem of service utilization and HIV care adherence by homeless PWLH is exacerbated by issues of **substance use and mental illness**. Significant associations have been found between substance use and adherence to HIV medications, and between substance use and high-risk sexual practices among homeless PWLH[28]. Homeless people living with HIV/AIDS are more likely to have ever or recently engaged in substance use and HIV transmission risk behaviors and housing status remains a significant predictor of number of sex partners (past 12 months), sex exchange (lifetime and past 12 months), unprotected sex with unknown status partners, and all drug and alcohol use variables for PWLH[29]. These issues can create barriers to prevention, education, client disclosure, and the ability to access medical and mental health services[30].

Among PWLH experiencing homelessness or imminent risk of homelessness, a **history of incarceration** is also a marker for ongoing risk behavior and health disparities[32]. Recent homelessness was **7.5 to 11.3 times more common** among jail inmates than in the general population[33]. Given that over the past two decades, HIV infection in the United States has become concentrated in prisons and jails, the widespread incarceration of persons with or at risk for HIV infection has important public health ramifications, including but not limited to the intra-prison spread of the virus. Interventions to enhance identification of infected inmates, prevention counseling, and treatment of inmates with HIV/AIDS are required to stem the contribution of incarceration to the spread of HIV infection[34].

In our own region, approximately **9%** of PWLH have a history of being incarcerated in the San Francisco jail system[35]. Of these, an estimated **292** individuals, accounting for nearly **three-quarters** of the incarcerated population, are injection drug users. The 2005 Hope Study examined the prevention and health service needs of HIV positive individuals in the San Francisco jail system. The study found that **69%** of the sample (n = **261**) lived in unstable housing during the month before incarceration. Such numbers highlight the need to emphasize and strengthen jail-based services as a vital homeless entry point for engagement and linkages to care for HIV positive out of care San Franciscans, including expansion of transitional case management services and enhanced coordination between jail-based and community providers and discharge planners.[36].

While there is a shortage of both short-term and long-term housing affordable housing throughout the United States, San Francisco is ranked as the most expensive metropolitan jurisdiction in the nation[37]. 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

Figure 2.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs, 2010[37]

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

the San Francisco Ryan White 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 2**).[38] 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".[39]

The prohibitively high costs of local housing have exacerbated the problem of homelessness. On January 27th, 2011, a community-wide Homeless Point-In-Time Count was performed using HUD recommended practices for counting homeless individuals. A total of **6,455** homeless persons were counted on this night while a 2011 Health Care for the Homeless report found **10,203** homeless in the city. More than half of this population (**55%**) suffer from a disabling condition and just under a third (**31%**) reported current substance abuse issues. The average homeless person in San Francisco is male (**68%**), African American (**39%**), between 31 and 50 years old (**55%**), has a disabling condition (**55%**), and is experiencing homelessness for the first time (**53%**)[40].

METHODOLOGY

Overview of the Intervention: As noted above, the San Francisco Department of Public Health's (SFDPH) Community Oriented Primary Care Program is requesting FY 2012 Ryan White Special Projects of National Significance (SPNS) funding to develop and implement the **HIV Homeless Outreach Mobile Engagement (HOME) Project** - a mobile, multidisciplinary team-based intervention specifically designed to engage and retain in care the most severely impacted and hardest-to-serve homeless persons living with HIV in San Francisco. The HOME Project will explicitly target those homeless individuals who are the **most difficult to engage and retain in care** - individuals facing complex, multiple co-morbidities and barriers who have thus far resisted attempts to engage them in housing and/or HIV treatment.

At the heart of the HIV Homeless Outreach Mobile Engagement Project is a **mobile multidisciplinary team** that will serve a caseload of **20 - 25** of the hardest to serve HIV-infected homeless individuals in San Francisco at any one time. Virtually **all** of these individuals will be homeless and living on the streets at the time of their admission to the program, since one of the key care barriers to care for this population is the lack of successful engagement in temporary or long-term housing. **The mobile team will form intense, one-on-one relationships with their client population, and will maintain almost daily contact with the individuals they serve.** During our project planning meetings, members of our group likened the relationship envisioned between the mobile team and each client as being one in which the multidisciplinary team "sticks" to each client in order to "glue" him or her to a patient-centered medical home for as long as needed. Mobile team members will meet homeless individuals **directly in the field** regardless of where they are living, and will follow them wherever they go, providing health monitoring; linkage to needed services; support for attaining stabilization; support with obtaining housing; and direct assistance in attending medical appointments and taking HIV medications following a regular schedule. **This includes serving as proxy deliverers of HIV medications and conducting in-the-field medication observations** to assess the degree to which clients are adhering to HIV treatment regimens. The team will also strive to create **multiple trust relationships** with clients so that if one member of the multidisciplinary team is not present on a

given day or leaves the team, a strong relationship still remains in place with other team members.

The proposed mobile team will consist of the following **five** highly trained homeless and HIV specialists:

- **Two Medical Social Workers (MSWs),** one working in the field on a **.75 FTE** basis and the other working in the field on a **.50 FTE** basis. The two MSWs will work as a sub-team to provide ongoing, comprehensive client assessments; develop and continually update collaborative client care plans; provide referrals to a full complement of health and psychosocial service resources and programs; and provide informal, field-based counseling and one-on-one support services to project clients.
- **One Psychiatric Registered Nurse (PsyRN)** working in the field on a **.20 FTE** basis to provide mobile health and psychiatric assessments and examinations; monitor medication and mental health status; and alert the team to emerging physical and mental health issues and needs. The PsyRN will also provide service intensification for identified patients needing enhanced adherence support.
- **One full-time Homeless Peer Navigator (1.0 FTE),** focused specifically on ensuring that clients are **linked to and able to access** all essential health, psychosocial, and support programs to which they are referred. This includes providing advocacy to secure placement in programs such as housing, mental health treatment, substance abuse treatment, or medical specialty care; accompanying clients to appointments where needed; and continually following up to ensure that ongoing client care linkages continue to occur.
- **One full-time Homeless Outreach Worker (1.0 FTE)** who plays a key role on the team by helping to locate and identify out-of-care homeless persons living with HIV; maintain continual contact with project clients; and follow up to locate homeless clients who for a variety of reasons become lost to the program, such as through transience, mental health or substance abuse episodes, or incarceration.

Members of the multidisciplinary specialist team will **continually meet together** to track the needs of their client population, and to coordinate team responsibilities in regard to linking and maintaining each individual served in HIV care. The team will conduct **weekly case conferences** to review client needs, often involving specialists and care providers from other relevant programs and agencies. This includes interactions with other homeless care teams and programs to ensure coordination and non-duplication of services, as well as with medical and behavioral health providers to ensure that the team's work continues to facilitate access to care in the most appropriate and effective manner possible. The team will most often **travel together** throughout the city to reach and care for their homeless clients, but in some cases will work individually to track down a patient who has been temporarily lost, or to accompany clients to appointments, or to help clients prepare applications or paperwork to support access to benefits programs or housing services. The team will **continually coordinate** its activities to ensure that client needs are met as rapidly as possible.

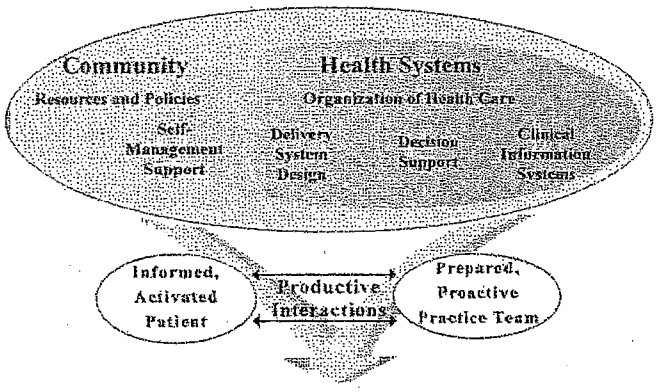
All individuals served through the multidisciplinary mobile team will be linked by the team to a **primary care provider** that will offer ongoing basic medical care to the homeless patient, including prescribing and monitoring HIV therapies. Virtually all patients will also be linked to a **consulting psychiatrist** for monitoring and prescription of psychotropic medications. Ensuring that project clients get to their medical and psychiatric appointments will be one of the primary

tasks of the mobile team, with responsibility for this falling most heavily on the Homeless Peer Navigator. At the same time, however, by providing a Psychiatric Registered Nurse as an integral part of the mobile team, the program will be able to provide **ongoing, field-based health and psychiatric assessments** that monitor and respond to client status. This resource is in turn is expected to greatly reduce emergency incidents while allowing the team to pro-actively respond to client health needs before they become critical issues.

Apart from facilitating a rapid and direct linkage to HIV care and treatment, the multidisciplinary mobile team's primary goal will be to ensure that homeless HIV-positive individuals with complex needs are housed as rapidly as possible. As noted in the needs assessment, housing is **directly linked** to dramatic reductions in individual morbidity and mortality, and is the single most important factor in ensuring the long-term health and well-being of project clients - potentially even more important than HIV treatment itself. The project team will use a complex, multi-pronged approach to ensuring housing access, including working in close collaboration with virtually every housing resource program in San Francisco to facilitate access to programs such as medical respite care, emergency shelter housing, short-term and permanent supportive housing, and SRO housing. Most project clients will require extensive stabilization services prior to successfully entering housing on a long-term basis - including health, mental health, and substance abuse treatment services - but the overriding aim of these services from the project's perspective will **always** be to get these individuals housed as quickly as possible, even if only for initial short-term periods to help acclimate them to permanent housing situations. The program will work to secure commitments of **priority housing access** for our population's clients wherever possible. **To facilitate the transition to housing, our program will also finance two dedicated short-term stabilization rooms that provide immediate access to housing while clients work to stabilize the conditions of their lives.** While the rooms will not guarantee long-term housing success or address the need to get client into permanent supportive housing - the only long-term housing solution for most of our clients - they will at least help provide a temporary bridge to housing for patients who are becoming more able to consider a long-term housing option.

Theoretical Basis and How the Model Addressed Identified Needs:

The Chronic Care Model



The HIV Homeless Outreach Mobile Engagement Project utilize a **chronic disease management approach** to care, based on the **Chronic Care Model** originally formalized by Wagner, et al.[41] This includes the use of **multidisciplinary teams** to provide holistic patient care; the integrated interaction of health and community support systems; an emphasis on a **wellness models** which incorporates preventive care and tools to help patients take a greater role in their own health care management; and **panel management** approaches that utilize **patient registries** to track client-level medical, behavioral,

health, and social indicators; ensure the quality of our work; and identify systemic gaps or patient issues. San Francisco as a whole is moving toward the creation of a **citywide electronic health exchange** to facilitate health care-related communication between medical, behavioral health, and social service members of client care teams. Within this electronic registry system, each client will have a **coordinated and continually updated care plan** embedded in their lifetime clinical record. This plan will allow members of the integrated team to track acuity of care needs, engagement in care, specific health indicators, and other factors that help ensure compliance with healthcare standards and target outcomes. The registry will also interface with housing and behavioral resource providers throughout the city so that the team can monitor from moment-to-moment factors such as client housing status, engagement in substance abuse and/or mental health treatment, and emergency care episodes.

On a general care level, the proposed intervention is designed to simultaneously address a broad range of key barriers and issues that keep multiply diagnosed homeless persons with HIV from regularly and comprehensively accessing HIV care and treatment. This includes approaches to diagnose, treat, and stabilize client mental health conditions, including the effects of trauma and violence; to diagnose and address substance abuse issues using a harm reduction and trauma-informed approach; and to link clients to stable supportive housing. The project will employ a **patient-centered medical home model** to deliver care in an identified, community-based setting through an identified primary care provider while providing a multidisciplinary mobile team to ensure access to supportive and benefits resources and to serve as a continual bridge to medical care services.[42] The chart below (see **Figure 3**) briefly summarizes some of the ways in which our proposed intervention addresses barriers to HIV care and retention identified in the needs assessment above.

Figure 3. Selected Barriers to HIV Care Engagement and Retention Addressed through the HOME Project

Identified Barriers and Issues	How Addressed through the HOME Project
▪ Lack of linkage to an identified patient-centered medical home to assess and treat HIV and to monitor and treat other chronic and non-chronic health issues	▪ Comprehensive field-based assessment of client needs followed by direct linkage to a primary medical home based on client's culture, language, location, physical, mental health, and substance use status, and cognitive and functional status ▪ Continual team-based support to help clients access medical home services, including accompanying patients to medical appointments and supporting adherence to medication regimens ▪ Development of strong trust relationships between the client and the members of the multidisciplinary team to overcome fear and mistrust of traditional medical services and prevent the client from dropping out of care

Identified Barriers and Issues	How Addressed through the HOME Project
▪ Lack of adequate housing to ensure stabilization and decrease morbidity and morality	▪ Ongoing assessment of client needs and linkage to essential services to help stabilize the individual and ready him or her for housing, including linkages to financial support, mental health services, and substance abuse treatment ▪ Linkage to grant-financed stabilization rooms to transition clients to longer-term housing ▪ Linkage to a broad range of housing resources in San Francisco, including housing advocacy and placement services; emergency shelter facilities; short term housing; and long term and permanent supportive housing
▪ Difficulty in coping with a range of co-occurring disorders and life issues, including poverty, homeless, mental health issues, substance abuse, and violence.	▪ Ensuring access and linkage to a comprehensive network of public and private supportive systems and programs in San Francisco, including complementary financial resources and benefits programs ▪ Providing case management and peer support services to continually assess client needs and develop concrete action plans to address them ▪ Providing mobile Medical Social Work support to provide intensive behavioral interventions to overcome immediate barriers to care access and retention
▪ Minimalization or marginalization of HIV care and risk issues in the context of daily life and survival priorities	▪ Ensuring access to supportive services to meet daily survival needs such as food and shelter to allow clients to focus on HIV care and medication adherence ▪ Development of innovative harm reduction and trauma-informed strategies in collaboration with each client to integrate medical care and medication adherence into day-to-day activities
▪ Resistance to engagement in care and support as a result of past discrimination and violence	▪ Ensuring the availability of respectful and non-judgmental staff who wherever possible reflect the cultural, linguistic, and gender orientation of the clients they serve ▪ Ensuring linkage to non-judgmental, culturally competent services that cross the spectrum of client needs
▪ Transient or non-existent engagement in HIV care and housing as a result of incarceration	▪ Ensuring transitional care to HIV-positive persons being released from the San Francisco jail system through a strong collaborative relationship with Forensic AIDS Project, Centerforce, and other programs
▪ Frequent use of urgent and emergency service systems by low-income populations	▪ Achieving client stabilization in regarding to housing, mental health conditions, and substance use status ▪ Ensuring engagement with a primary medical home that encompasses regular patient treatment, panel management for chronic conditions, and preventive health services ▪ Providing access to medical respite care, shelter services, and housing services to preclude the need for ER visits as a strategy to obtain shelter

Key Project Partners and Operating Structure: The HOME Project will utilize a **collaborative, public / private service partnership** to organize and deliver its innovative model of multidisciplinary mobile care and support for the most intensely impacted out-of-care homeless persons living with HIV in San Francisco. Among other factors, the project will base members of its multidisciplinary team **at several different sites** so that they can interact with and draw from the expertise of complementary homeless and HIV staff and programs and in turn bring that expertise back to the team. The project will also utilize and leverage a broad range of complementary outreach, linkage, medical care, housing, substance abuse, mental health, and case management services to increase the impact and cost-effectiveness of the SPNS program while maximizing existing initiatives and resources.

The grantee for the HOME Project will be the **San Francisco Department of Public Health** and its **Community Oriented Primary Care** program. COPC encompasses a network of **12** large-scale public FQHC clinics specifically focused on the health needs and communities in which they are based, and maintains and oversees numerous grants and contracts that incorporate extensive evaluation components. One of the key providers in the COPC network is the **Tom Waddell Health Center,** an FQHC-qualified, neighborhood-based facility that provides care to the most highly disadvantaged populations in the Tenderloin neighborhood of San Francisco. The mission of the Center is to provide comprehensive health care for homeless people and for other severely underserved individuals in the community. At its home clinic, the Tom Waddell Health Center provides care to nearly **9,000** residents of supportive housing in San Francisco per year, nearly all of them individuals coping with mental health diagnoses and substance abuse issues. The Center has a specialty in providing **health care for the homeless**, including through the soon-to-be-merged **Housing and Urban Health Clinic**, which currently serves over **1,000** patients in subsidized housing programs. Services provided through the Clinic include primary linked medical and psychiatric care; substance abuse counseling and detox referral; HIV and STD screening and treatment; health education; GYN services; medication adherence; and phlebotomy. The Housing Clinic also incorporates **Action Point**, an HIV medication adherence initiative that also assesses and addresses housing retention and related areas. Medical staff of the Tom Waddell Health Center will provide comprehensive medical care for HOME Project clients through **all three** of the program's proposed medical home sites, including the Center itself, the Tenderloin Area Center of Excellence, and the integrated intensive behavioral health program at South of Market Mental Health (see p. 17 below).

The HOME Project's **in-kind Principal Investigator, Dr. Deborah Borne**, currently serves as Clinical Director for Integration and HIV Care within the San Francisco Department of Public Health's Homeless and Community Based Programs section. Dr. Borne has a close association with the Tom Waddell Health Center, having served as Medical Director for the Center from 2006 to 2011. As a nationally recognized integrated health care planner who is situated directly at the hub of HIV, homelessness, and behavioral health services integration in San Francisco, Dr. Borne is ideally positioned both to oversee our multidisciplinary team and ensure the team's broader inter-coordination with the full spectrum of project-related resources in our region. Dr. Borne also has extensive research and evaluation experience.

The HOME Project will base its 20% time Psychiatric Registered Nurse (PsyRN) directly within the Tom Waddell Health Center. The PsyRN will be a highly trained, advanced practice professional with extensive experience working with and treating homeless populations. As a member of the project's multidisciplinary mobile team, the PsyRN will provide field-based assessments to monitor and maintain patient health and facilitate access to

care before conditions begin to serve as barriers to HIV treatment. The PsyRN will also function as a member of the Tom Waddell Health Center multidisciplinary team, and will be able to take emerging knowledge and approaches in HIV and homeless care directly into the field and share them with other members of the mobile team and with project clients.

In a parallel way, the HOME Project will base its proposed full-time Homeless Outreach Worker within the San Francisco Homeless Outreach Team (SF HOT). SF HOT is an ambitious public / private partnership involving the non-profit Community Access and Treatment Services, Inc. (CATS), the San Francisco Department of Public Health, and the San Francisco Human Services Agency (HSA). The program involves approximately **85** staff who actively outreach and engage people living in the streets and shelters. SF HOT recruits individuals who are sleeping on the streets and engages clients in emergency shelters, food programs, and even the public library. SF HOT also controls approximately **274** stabilization units that can move people off the streets into basic housing in less than 24 hours. SF HOT staff are flexible, kind, tenacious, and persistent and have an outstanding track record of engaging complex homeless populations. Overall, SF HOT carries a caseload of **943** clients and has a median length of time of service of **18 months**. SF HOT usually terminates case management with clients within **6 months** of placement in permanent housing when the on-site case management team can take over primary case management responsibilities. By basing the HOME Project's Homeless Outreach Worker within the SF HOT program as a whole, the Outreach Worker will be able to coordinate care and outreach to target the most difficult "outliers" among HIV-positive, out of care homeless populations in the city. At the same time, the SPNS-funded Outreach Worker will expand expertise through association with the SF HOT team that he or she can bring to the HOME Project team. The close relationship between SF HOT and out Homeless Outreach Worker will also ensure a seamless transition when clients are either moved off or moved onto the HOME Project caseload.

Existing hiring constraints within the San Francisco Department of Public Health limit the extent to which the department can hire new project staff whose employment terms are initially set by grant parameters. At the same time, the hiring process for new County employees is cumbersome and time consuming, and indirect cost rates at the County level are high. More importantly, community-based agencies bring a complementary perspective to their work with underserved populations - one that is less oriented toward macro systems integration and more oriented to the actual experience day-to-day of delivering and enhancing one-on-one client services to complex populations.

For these reasons, SFDPH will partner with **Asian & Pacific Islander Wellness Center (A&PI Wellness Center)**, a non-profit, multi-service community-based agency established in 1987 to address the crisis of HIV and AIDS in the Asian community. A&PI Wellness Center operates the **HIV Care Program** which provides case management, mental health counseling, and substance abuse counseling for marginal and underserved persons living with HIV from **all** ethnic and cultural groups. The agency also co-operates the Ryan White-funded **Tenderloin Center of Excellence (TACoE)** in collaboration with Tom Waddell Health Center and the Harm Reduction Therapy Center. The Center also recently established a **Wellness Clinic** providing free primary medical are to low-income, uninsured individuals one day per week.

Through a subcontract, A&PI Wellness will hire **three** key HOME Project employees: 1) a **full-time Medical Social Worker** who will work half time as Project Director / Evaluation Coordinator and half-time as mobile social worker; 2) a **75% time Medical Social Worker** who will also provide mobile-field based services; and 3) a **full-time Homeless Peer Navigator** who

will work with homeless clients to ensure that they are directly linked to all essential service and support programs to which they are referred. Project staff will be appointed through a **collaborative process** with the Department of Public Health and will work in close partnership with the Department to ensure ongoing integration with staff hired through other County departments.

The Project Director and other staff based at A&PI Wellness - as well as project staff based at County agencies - will work under the direct supervision of the in-kind **Principal Investigator**, Dr. Deborah Borne, and the Project's half-time MSW **Project Director / Evaluation Coordinator**. The team will continually partner together to deliver street-based services to the project's target populations while gathering as a team at least **weekly** to discuss scheduling, patient progress, and emerging patient issues. These weekly meetings will also incorporate **informal case conferencing** to address specific client needs which may involve attendance by staff of other relevant agencies and programs.

The HOME Project will also be coordinated through a **Project Management Team.** The Team will incorporate all SPNS program staff along with representatives of the key partner agencies involved in the intervention, including representatives of the Tom Waddell Health Center, Asian & Pacific Islander Wellness Center, SF Housing and Urban Health, SF Homeless Connect, the SF HOT Team, and Forensic AIDS Project. The Management Team will meet on at least a **monthly** basis during the initial project year to plan and implement project services and to track and refine mobile team strategies and approaches. The Team will also help design and oversee the program's internal evaluation process designed to assess but quantitative and qualitative outcomes of the intervention.

Client Population Characteristics and Sources: As noted above, the HIV Homeless Outreach Mobile Engagement Project will specifically focus on serving what our project is describing as the "hardest to serve" HIV-positive homeless individuals in San Francisco - individuals that our advanced system has thus far been unable to retain in care and who face multiple co-morbidities accompanied by chaotic life circumstances that constitute formidable barriers to linkage and retention in care. At minimum, clients enrolled in our demonstration will be required to meet the following **six** admission criteria:

1. Have received a previous positive HIV test result;
2. Be living on the street or in HRSA-defined unstable housing situations;
3. Have identified psychiatric disorders and/or mental health conditions;
4. Have active substance abuse and/or chemical dependency issues;
5. Be an individual who is not currently engaged in HIV treatment or therapy; **and**
6. Be an individual who is not currently linked to an identified medical home.

The HOME Project will utilize **four** primary sources for identifying hardest-to-serve HIV-infected homeless individuals for inclusion in our program, as follows:

✓ Approximately **20%** of project clients will be **newly identified HIV-positive homeless individuals** facing multiple co-morbidities who have been tested through a variety of programs including medically-related testing at the Tom Waddell Health Center; rapid testing through the TWHC Urgent Care center; and testing at public and private hospitals and clinics. Many of these individuals will be referred to the HOME Project through the **LINCS**

(Linkage Integration Navigation and Comprehensive Services) program, which employs a citywide team of trained individuals who partner with newly identified HIV-positive individuals to provide intensive care linkage support for up to three months following an initial HIV diagnosis. The LINCS program is a key component of the city's Enhanced Comprehensive Planning and Implementation for MSAs Most Affected by HIV/AIDS (ECHPP) Initiative through which San Francisco is collaborating with the CDC and a range of local agencies to enhance collaborative approaches to identifying and involving care new HIV-positive individuals. A significant number of HOME Project clients will also originate through the work of the **SF HOT team** described above which incorporates questions regarding HIV status into their existing outreach strategy.

✓ Another **25%** of project clients will consist of homeless clients of the **Tom Waddell Health Center** who at some point in the past received HIV care at the Center but who, for a variety of reasons, have been lost to HIV care for anywhere from three months to several years.

✓ Approximately **15%** of project clients will consist of pre-identified **high users of multiple systems (HUM)**, known in other jurisdictions as "hot spotters." These are low-income individuals who frequently utilize emergency rooms and urgent care centers to obtain basic health treatment. These individuals are identified by San Francisco using the city's **Coordinated Case Management Data System (CCMS),** an integrated electronic charting, reporting, and communication tool for teams working with clients who are served across multiple systems of care. CCMS pulls client histories routinely from over **20** databases across **five** city departments and integrates them into one electronic medical record, making it the first-ever comprehensive database of adult vulnerable clients in San Francisco.[1] In Fiscal Year 2009-2010 alone, the system identified at least **2,300** individuals who obtained urgent and/or emergency medical care from multiple care systems, more than **90%** of whom had histories of chronic homelessness. Estimates of the percentage of this population living with HIV based on ICD-9-CM codes from AHRQ range from **9%** to **12%** of the total HUM population, which would mean that somewhere between **200** and **275** high users of multiple systems were persons living with HIV. A consortium of local providers meets monthly to discuss treatment for this group and will refer HIV-positive patients to the Home Project.

✓ The remaining **40%** of project clients will be persons identified through an active citywide collaboration that engages public and private providers in an effort to link the most challenging HIV-positive homeless individuals in our region into care. Many of the referrals through this component will come from one of the Tom Waddell Health Center's **15** satellite

[1] CCMS integrates elements of formerly separate databases for medical health, ambulance transports, mental health, substance abuse, jail health, county benefits, shelters, and supported housing. This leap in technology is the result of individually-crafted database linkages and routine transfers of information and no change has been imposed on the underlying databases. The nearly 300,000 patients included thus far in CCMS, with as much as 20 years of service histories included, represent individuals deemed to be San Francisco's most vulnerable citizens. All patients are unduplicated and are assigned a unique identifier regardless of various aliases used previously. All are adults ages 18 and older. They include ambulance high users, urgent care users, homeless people, frail elderly patients, gravely disabled alcoholics, and high users across multiple systems (HUMS). These are individuals whose care is complex and multifaceted. Plans are in place for continued growth of the warehouse until all persons receiving safety net care from the City – whether emergency, stabilization, or prevention services – are included.

medical clinics along with street outreach teams, needle exchange programs, hospital emergency rooms, emergency shelters, and battered women's shelters. Additional key referral partnership include:

- **Project Homeless Connect**, providing a single location through which non-profit medical and social service providers can collaborate to serve the homeless of San Francisco with comprehensive, holistic services. Through Project Homeless Connect, over 1,000 community volunteers partner with government agencies, nonprofits, and the private sector **every two months** in a single location to provide comprehensive health and human services for homeless San Franciscans. Hundreds of corporations, nonprofits, and government agencies provide PHC and its clients with services such as dental care, eyeglasses, family support, food, HIV testing, housing, hygiene products, medical care, mental health services, substance abuse treatment, SSI benefits, legal advice, California identification cards, voice mail, employment counseling and job placement, wheelchair repair, methadone, needle exchange, and more.
- **Forensic AIDS Project** (FAP), a Ryan White-funded program that functions as one of the San Francisco EMA's HIV Centers of Excellence and provides a unique one-stop, comprehensive care center providing jail-based health services and post-release treatment and care linkage services to incarcerated persons with HIV. FAP 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.
- **Centerforce,** which provides pre and post-release transitional support services for HIV-positive individuals being released from San Quentin State Prison just north of San Francisco.
- The **Behavioral Health Access Center (BHAC)** which serves as the assessment, referral and placement unit of the Community Behavioral Health Services section of the San Francisco Department of Public Health. BHAC conducts direct intakes and assessments of homeless clients in San Francisco who are dealing with intensive behavioral issues including severe and persistent mental illness and chronic substance abuse, and provides referrals and linkage support to connect them to services and providers throughout the city. Once assessed, individuals may be placed in outpatient treatment, residential treatment, or connected to other appropriate services in the community.

During the initial project year - following an initial three-month start-up period - virtually all project clients will originate from the rolls of HIV-diagnosed homeless clients who have been previously served through the Tom Waddell Health Center but who have been lost to care at some point in the past. The project's **Homeless Outreach Worker** will play a key role in helping locate and make initial contact with these individuals. The multidisciplinary team will add clients gradually, in order to establish trust relationships and focus on an intensive period of client stabilization following enrollment in the demonstration. Approximately **12** clients are expected to be enrolled during the initial four-month period from January 1 through April 30, 2013, while another **8 - 13** clients will be enrolled between May 1 and August 31, 2013, or until the team's maximum caseload is reached. **Clients will receive support through the multidisciplinary team for as long as support is needed to link and retain them in HIV care and to ensure that they are successfully placed in long-term housing.** As of this writing, the

average client stay in the program is anticipated to be between **4 and 5 months.** However, the actual average length of stay in the program could be less than or greater than this based on the team's actual experience. Based on an average fourth-month term of engagement, the team expects to serve an average of approximately **50** unduplicated homeless HIV-positive clients each year, or a total of roughly **250** clients over the five-year project period.

It is important to note that because the project is addressing a complex and severely underserved population, the HOME team will need to be **flexible** in responding to client needs and conditions over time. This need for flexibility may mean potential changes in projected service targets. For example, some clients may continue to need support from the multidisciplinary team for six months or even a full year following enrollment in the program. In such cases, the team may be able to provide a less intensive level of support to long-term clients, meaning that the team could potentially accommodate a larger client caseload during some phases of the project. Similarly, despite the team's efforts, some clients may temporarily become lost to the program - such as when they leave town - and could be readmitted to the program following their reappearance in the city. In yet other cases, clients could become stabilized relatively quickly following receipt of appropriate, focused mental health, substance abuse, and medical services, and could be transitioned to a less intensive level of care or case management is a matter of a few weeks. This in turn could increase the total number of clients the multidisciplinary team is able to serve in a given year.

Regardless of the circumstances, however, the primary goal of the team will be to never lose contact with a client regardless of how difficult keeping contact with that client is, and regardless of how resistant the client may be to receiving services. This is a key way in which the intervention will differ from prior approaches. While never forcing or compelling a client to receive services that she or he does not wish to receive, the team will never lose contact with the individual, and never give up fighting to help a client willingly access needed services and support. This goal will be strongly reinforced through our region's unique use of **registries** created through the CCMS and medical EMR systems, which have made what would have seemed a hyperbolic dream a decade ago into an attainable reality. All **250** clients served through the HOME Project will remain in the registry both during and following the SPNS intervention, with client care engagement, treatment adherence, viral load levels, and other indicators being reviewed regularly, and with appropriate interventions continually undertaken to ensure long-term housing, engagement in medical care, and HIV medication adherence.

Initial Client Engagement & Linkage to HIV and Related Services: The HOME Project team will develop and utilize a **preliminary assessment tool** to determine client eligibility and appropriateness for the SPNS intervention, in part using the standardized **Homeless Vulnerability Index** developed by Boston's Health Care for the Homeless Program and now in use in many US jurisdictions (see Evaluation Capacity below for a more detailed description of this tool). The HOME Project team will ensure that all potential clients meet the six broad program criteria outlined and will cross-check potential clients using the CCMS database to ensure that individuals are not currently affiliated with a primary medical home. Potential clients will be informed of all project services and will sign written consent forms prior to program admission.

Newly admitted clients will complete a more **comprehensive client needs assessment and history** which documents prior medical conditions and major life events and identifies all present conditions and factors that exist in the client's life, including known medical and health

conditions; past HIV treatment received; known mental health and psychiatric issues; history of past trauma; substance abuse and chemical dependency issues; cognitive and functional status; economic and housing circumstances; benefits eligibility; survival needs; current threats of or actual violence or physical abuse; extent and composition of social support networks; and engagement in HIV-related risk behaviors. The needs assessment and history may need to be completed over **multiple sessions,** and the multidisciplinary team will meet together to review the assessment and develop preliminary care and stabilization recommendations for the client that are triaged based on a range of factors including threats of violence, threats to survival, and mental health and substance abuse-related stability issues. A **comprehensive care plan** will then be developed and signed in collaboration with the client, outlining specific action steps and service linkages to be undertaken on behalf of and with the participation of the client, including proposed timeframes for attaining HIV care engagement and engagement in stable housing.

Apart from meeting immediate survival needs, removing physical threats, and creating adequate stability to obtain medical care, the initial goal of the HOME Project team will be to involve and retain clients in a designated patient-centered medical home. The designated medical home will be an FQHC-qualified facility with access to citywide registries which serves as the hub location at which clients will access comprehensive HIV-specific and non-HIV-specific health and medical services. For many project clients, their most appropriate designated medical home will be the **Tom Waddell Health Center**. Located in the Tenderloin neighborhood of San Francisco, the Health Center has over 20 years of experience in providing community-based health care to homeless persons living with HIV, including persons coping with severe mental illness and substance abuse issues. Tom Waddell Health Center is an ideal site for project clients who have achieved a higher level of stabilization and are able to keep at least some appointments on their own and to utilize a medical clinic setting without becoming a danger to themselves and others. An estimated **35% - 40%** of project clients will be appropriate candidates for the Tom Waddell Health Center following their initial encounter with the HOME Project team.

Other HOME Project clients will be triaged into a more intensive medical care environment at the Ryan White-funded **Tenderloin Center of Excellence (TACoE)**, a collaborative care initiative for severe needs homeless populations with HIV which encompasses the Tom Waddell Health Center, the Asian & Pacific Islander Wellness Center, and the Harm Reduction Therapy Center. TACoE provides comprehensive medical care, medical and psychosocial case management, substance abuse treatment, mental health services, and treatment adherence services to severe need populations with a focus on homeless and marginally housed individuals, active substance users, transgender persons, Asian / Pacific Islander groups, and formerly incarcerated populations. TACoE is able to provide effective medical care to a more chaotic and less highly stabilized population than Tom Waddell Health Center, and can serve as ideal bridge program for clients who have not been fully stabilized and housed. Approximately **35% - 40%** of project clients will initially receive HIV treatment services to TACoE.

In September 2011, Community Behavioral Services received SAMHSA funding to implement the **Integrated San Francisco Primary Care Behavioral Health (SF PBHCI)** Initiative in the amount of $1.9 million over four years. The program is designed to provide integrated primary and behavioral health care, care management, and wellness programs to seriously mentally ill clients who have previously been unconnected to primary care and at high risk for chronic conditions such as metabolic syndrome, diabetes, HIV, TB, and hepatitis C. The project serves a culturally diverse group of indigent and uninsured severely mentally ill clients,

many of whom are homeless or marginally housed. Through the program, clients receive primary care and wellness services in the mental health setting with an emphasis on preventive screening and self-management of chronic conditions. The SF PBHCI initiative is designed ensure that seriously mentally ill clients - including many HOME Project clients - become connected to a full-scope, person-centered, culturally competent healthcare home, thus reducing dependence on emergency services, improving chronic condition self-management and improving overall health status. This program - which provides care through the **Mental Health Outpatient Unit** at **South of Market Mental Health Services** - will be the initial medical home for HOME Project clients who are impacted by severe and persistent mental illness. The Outpatient Unit utilizes a core team that provides an array of clinic-based integrated medical and mental health services to individuals living with acute psychiatric conditions, in a safe, culturally competent setting. The team has extensive experience working with disadvantaged and homeless populations with HIV. At least **20%** of the project population is expected to require initial access to HIV medical home services through this facility.

Housing Resources and Support: Members of the HOME Project multidisciplinary team will work closely with project clients and with existing local resources to implement a **staged process** for moving out-of-care homeless persons with HIV into permanent housing situations. The structure of the process will consist of **four** phases: 1) Engagement and Treatment; 2) Move-in Assistance; 3) Stabilization and Treatment in Housing; and 4) Eviction Prevention. San Francisco has demonstrated that by using this model it is possible to break the cycle of homelessness and prevent eviction in most cases. Even so, we also understand that we will be working with individuals whose lifetime addictions make them much more likely to exhibit behavior that leads to eviction. Many of the clients we serve will also require more intensive stabilization assistance than other homeless populations, and may experience several periods of short-term housing before they are able to settle in permanent housing. As such, HUH will have a system in place to quickly re-house evicted tenants in alternative DAH housing to achieve the goal of eventually housing all persons with HIV in San Francisco.

As noted above, our region benefits from the unique and significant investments in short and long-term housing that have been made by the City and County of San Francisco Department of Public Health to address the local homelessness crisis. In contrast to virtually every other county health department in the US, SFPDH **maintains and controls its own extensive portfolio of housing**. This means that the Department does not have to negotiate exclusively with federal or affordable housing partners to access housing resources, and does not always have to compete for admission to housing slots that it does not control. Through the department's controls of its own housing, the Home Project will be able to **reliably deliver** on its promise to place multiply diagnosed clients with HIV in both short and long-term housing when they have been adequately stabilized.

The Department of Public Health's housing portfolio is maintained through San Francisco **Housing and Urban Health (HUH)** and its **Direct Access to Housing (DAH) program.** Founded in 1998, Direct Access to Housing is a permanent supportive housing program targeting low-income San Francisco residents who are homeless or at risk of homelessness and who have one more identified special needs. DAH is a "low threshold" program that accepts adults into permanent housing directly from the streets as well as from shelters, hospitals and long-term care facilities, DAH strives to help tenants stabilize and improve their health outcomes despite co-occurring mental health issues, alcohol and substance abuse problems, and/or chronic medical

conditions. Unique in its on-site provision of wrap-around support services, DAH currently houses nearly **1,000** formerly homeless persons through a master lease program across **24** different sites scattered throughout the City of San Francisco. By 2013, DAH will expand to house at least **650 additional** tenants at **seven** new housing sites.

Key additional housing opportunities for Project HOME clients will include the **Housing First Single Room Occupancy (SRO) Master Lease Program** for homeless singles or couples who are receiving support through County Adult Assistance Programs; **Shelter Plus Care** for singles, couples, or families in which at least one adult has a certified disability due to mental health, HIV/AIDS, or substance abuse; and the **Local Operating Subsidy Program (LOSP)**, providing housing to chronically homeless adults and families with a certified disability. Scores of additional affordable housing sites in the city accept applications from potential subsidized housing tenants and will place potential residents on waiting lists. A comprehensive list of these housing sites is maintained by volunteers who work within the San Francisco Human Services Agency's Housing and Homeless Division. The Agency also maintains **eight** permanent, multi-service emergency shelter locations throughout the city and operates winter shelter and homeless storage facilities.

The two proposed **stabilization rooms** to be subsidized and set aside through the SPNS grant specifically for HOME Project clients will be provided through the city's Ryan White-funded **Emergency Housing Program for People living with HIV/AIDS** program, operated by Lutheran Social Services. The assigned stabilization rooms will be located within the 21-unit Kinney Hotel at 410 Eddy Street in the Tenderloin, which includes an office in which the Stabilization Program Coordinator (SPC) is based. Clients served by the program clients often present with a variety of special needs in addition to their HIV diagnosis, such as a history of chemical dependency and/or chronic mental health diagnoses. Stabilization rooms provide an opportunity for clients to be temporarily freed from concerns regarding shelter and basic survival needs so that they can focus on initial entry into HIV medical care and mental health and substance abuse treatment while longer-term housing opportunities are assessed. The SPC communicates with referring agencies on a daily basis to ensure up-to-date information on room availability and timely referrals. Only clients connected to assigned case managers are able be referred to the program. The maximum length of stay in the stabilization rooms is **28 days**. Clients are not required to pay any rent or program fees while housed in the program.

Substance Abuse, Mental Health, and Violence Prevention Resources: HOME Project clients will be referred and linked to a broad range of mental health, substance abuse, and other resources designed to address key barriers to HIV care access and retention. In regard to **substance abuse**, for example, clients in need of emergency detoxification services will be referred to the **San Francisco Sobering Center**, a program operated by San Francisco Housing and Urban Health. The Center provides acute overnight detox services along with medication administration and referral to longer-term detox, with the goal of diverting clients from Emergency Room utilization. **Walden House**, a respected non-profit substance abuse treatment agency, provides a longer-term, four to five day social detox program along with referrals to longer term drug treatment programs. Walden House also provides a wide range of residential drug treatment options. **The Joe Healy Medical Detoxification Project** provides drug detox, residential drug treatment, and substance abuse treatment with a specialty in services to persons living with HIV/AIDS.

It is expected that at least **70%** of HOME Project clients will be individuals who are living with severe and persistent mental illness and these clients will be linked to a spectrum of providers based on each client's individual needs and cognitive status. As noted above, the **Behavioral Health Access Center (BHAC)** serves as the assessment, referral and placement unit for SFDPH Community Behavioral Health Services and conducts direct intakes and assessments of homeless clients who are dealing with intensive behavioral issues including severe and persistent mental illness and chronic substance abuse. The BHAC program serves as the region's **initial triage point** for severely mentally ill homeless persons, and the HOME Project team will utilize and closely coordinate its work with that of the Center.

Meanwhile, the **Dore Urgent Care Center** provides emergency psychiatric services using a social model rehabilitation approach to crisis intervention. The program is designed to assist public and private emergency systems by accepting adult clients in psychiatric crisis who do **not** require hospitalization. The **Westside Crisis Clinic,** operated by Westside Mental Health Center, provides voluntary, drop-in psychiatric crisis and urgent care services to San Francisco adults 18 years and older. The Clinic is designed to stabilize low-income residents in a mental health crisis and refer them to appropriate sources for follow-up treatment. The Clinic can refill medications and provide longer-term residential mental health services. The **South of Market Mental Health Center** operated by the San Francisco Department of Public Health Community Behavioral Services provides comprehensive mental health services, including psychiatric evaluation, consultation, and prescribing and mental health screening and group and individuals counseling. **Tenderloin Health** is a non-profit CBO providing outpatient mental health and substance abuse assessment and treatment from a holistic perspective, incorporating individual and group counseling and drop-in services. The **Tenderloin Self-Help Center** operated by Central City Hospitality House provides episodic, drop-in support for mentally ill clients through a storefront location at Turk and 6th Streets. **Psychiatric Emergency Services at San Francisco General Hospital** serves as the city's public psychiatric emergency and inpatient facility, providing short-term counseling of individuals and families, crisis intervention, medication interventions, referrals to community clinics, and hospitalization as needed.

Additional services will be available to HOME Project clients. In addition to the San Francisco Sobering Center and the Tenderloin Self-Help Center described above, drop-in services are available at the St. Vincent de Paul Society **Multi-Service Center South** which offers shower and laundry services and serves as a space for an out-based, city-operated homeless medical clinic. **Project Homeless Connect** provides a direct linkage to scores of behavioral and supportive services for homeless individuals in a single-stop location. **A Woman's Place** provides gender-specific emergency shelter and transitional housing for homeless women and victims of crimes such as domestic violence, rape, and sexual assault along with a comprehensive range of flexible services including health care, mental health counseling, case management services, and money management. The facility specializes in serving chronically homeless woman who are most at risk and provides emergency and transitional housing for **up to 12 months** for single women without children, the LGBT and HIV/AIDS communities, and persons experiencing mental illness, domestic violence, and substance abuse.

Medical respite care is another critical recourse for medically ill homeless clients. Medical respite care consists of acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital. Unlike "respite" for caregivers, "medical respite" consists of short-term residential care that allows homeless individuals the opportunity to rest in a safe

environment while accessing medical care and other supportive services. Medical respite care is offered in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing. Respite services decrease the need for higher levels of care - such as hospital or ER care - and serve as an essential component of homeless health care. The **National Healthcare for the Homeless Council** maintains a directory of medical respite providers throughout the US, including in San Francisco. One of the leading local medical respite facilities is operated by San Francisco Housing and Urban Health. The facility provides a step down unit from an acute hospital for up to **50** adults at any given time and incorporates 24-hour nursing care in the style of a skilled nursing facility. It is hoped that the project will also prioritize facility access for appropriate HOME Project clients.

Integration with Emerging Healthcare Initiatives and Paradigms: The proposed HOME Project directly responds to and incorporates a broad range of emerging trends, initiatives, and paradigms in both HIV care and healthcare reform. The proposed intervention, for example, directly addresses several key elements of the 2010 **National HIV/AIDS Strategy for the United States.**[43] In terms of the Strategy's second goal of Increasing Access to Care and Improving Health Outcomes for People Living with HIV, the program's use of a mobile, multidisciplinary team to link clients a to comprehensive range of services while providing long-term monitoring and support responds to **all three** of the action steps encompassed by this goal, including: 1) Establishing a seamless system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV; 2) Taking deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV; and 3) Supporting people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing. Through its use of highly developed, cross-disciplinary service collaborations, the program also addresses the key action step of increasing the coordination of HIV programs across the Federal government and between federal agencies and state, territorial, tribal, and local governments.

The HOME Project also directly addresses and corresponds to goals of the **National Strategy for Quality Improvement in Health Care (The National Quality Strategy)** currently being implemented by the US Department of Health and Human Services. Launched in March 2011, the Strategy provides a blueprint for health stakeholders designed to prioritize quality improvement efforts, share lessons, and measure collective success. Our proposed intervention is specifically relevant to Goal # 1 which focuses on "improving the overall quality of care, by making health care more patient-centered, reliable, accessible, and

Figure 4.
The Six Priorities of the National Strategy for Quality Improvement in Health Care

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family are engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

safe."[44] The proposed intervention also addresses all of the National Quality Strategy's **six** priorities, as listed in **Figure 4.** In addition, Dr. Deborah Borne, our project's proposed in-Principal Investigator, serves as a Steering Committee member for the National Quality Center's **"In+Care" Campaign,** focusing on retention in care for HIV/AIDS clients. Dr. Borne's involvement in the campaign will allow her to integrate concepts and standards of care from the campaign into the proposed initiative.

Both the State of California and the City and County of San Francisco have also taken significant strides toward implementation of the **Affordable Care Act (ACA).** The city's groundbreaking **San Francisco Health Plan,** founded in 2009, is a licensed, city-sponsored community health plan that provides affordable health care coverage to over **70,000** low and moderate-income families. Members have access to a full spectrum of medical services including preventive care, specialty care, hospitalization, prescription drugs, and family planning services. Members choose from over **2,300** primary care providers and specialists, **6** hospitals, and **200** pharmacies - all in neighborhoods close to where they live. The Health Plan has been extremely supportive of SFDPH efforts to improve and innovate the quality of HIV care, and ensure that HIV is addressed with the same level of excellence as other chronic illnesses. This program is complemented by **Healthy San Francisco,** another city program that makes health care services accessible and affordable for uninsured residents through the placement of clients in **medical homes** and an emphasis on a **wellness model** of care. All city-funded health centers, including those involved in the present application, are moving toward medical home status, giving them access to expanded city and state healthcare reimbursement support.

These efforts have more recently been augmented at the State level by creation of the **Low-Income Health Program (LIHP),** the State's first step toward implementing health care reform. Also known as "California's Bridge to Reform" and established through the Section 1115 Medicaid Demonstration Program," the program expands Medicaid eligibility for low-income persons living at up to 200% of Federal Poverty Level in 25 of California's 58 counties. The LIHP demonstration will give the State a major head start in enrolling populations in Medicaid prior to the implementation of the ACA. These efforts are being complemented by the State's **Medi-Cal Managed Care Expansion Program,** which is expanding enrollment of up to **800,000** Medicaid eligible individuals - including persons with HIV - in Medicaid managed care programs.

The HOME Project also addresses and complements key emerging paradigms and initiatives in relation to HIV prevention on both a national and local level. San Francisco, for example, is closely involved in the CDC-funded **Enhanced Comprehensive HIV Planning and Implementation for EMAs Most Affected by HIV/AIDS (ECHPP)** initiative for high-impact HIV regions, which will further enhance coordination and integration of local HIV prevention and care linkage programs. One of the key sources of project clients for our own program will be the Department of Public Health's **Linkage Integration Navigation and Comprehensive Services (LINCS)** program described in greater detail below, which is part of the ECHPP strategy. San Francisco is also one of six CDC-funded **Program Planning and Service Integration (PCSI)** demonstrations designed to extend the reach of prevention services and combine and streamline health services for diseases with similar characteristics, such as HIV/AIDS, sexually transmitted diseases (STDs), viral hepatitis and tuberculosis.

Potential for Project Replication: The HOME Project offers a broad range of opportunities for replication in both smaller and larger urban jurisdictions throughout the US.

The HOME Project intervention is designed in many ways to serve as a **laboratory** through which San Francisco can implement and test a unique medical home intervention that is specifically focused on the most chaotic, complex, and intractable populations in the entire HIV service system. Through the HOME Project, a team of highly trained specialists dedicated to a relatively small client population will be able to experiment with and test a variety of interventions and approaches designed to achieve long-term engagement in HIV care and housing for a population that has thus far proven to be virtually impervious to traditional outreach and linkage efforts. Through the HOME Project, team members will build **lasting friendships** with project clients while doing everything in their power to coax, cajole, and urge clients into accepting the care, treatment, and housing they need to improve the quality and length of their lives. Team members will continually track and report on these experiences, and will develop ongoing program refinements in collaboration with the Project Management Team and other HIV and housing specialists that eventually result in the formalization of a series of effective, demonstrated, and workable models of care engagement. These models can in turn then be adopted in whole or in part by other jurisdictions as a strategy for reaching and involving the most challenging and problematic clients in their regions.

Among the specific potential replication products to be produced and disseminated by the HOME Project are the following:

- New standardized assessment tools that map the needs, histories, and social and economic conditions of the hardest to serve homeless persons living with HIV.
- New recommendations for triaging needs among hardest-to-serve populations in order to bring about incremental life changes in sequences most likely to achieve long-term success.
- New approaches to team-based interaction in the field, including recommendations for when and how to best meet clients, how often, and with what specific staff configurations to achieve specific stabilization and engagement goals.
- New models for improving access to and integration of medical, behavioral health, and psychosocial services among severely mentally ill and substance-addicted populations, regardless of their HIV status.
- New approaches to address and reduce HIV risk behaviors among homeless HIV-infected populations.
- New models for utilizing registry-based systems to track challenging HIV-positive populations over time and to monitor their utilization of health and social services, along with recommendations for when and how to intervene to address barriers and attain re-stabilization.
- Production of a comprehensive **replication tool kit** to help agencies implement some or all of the HOME Project initiative, including advice for utilizing existing staff to conduct street-based outreach and engagement services for this population.

- Provision of technical support and assistance services to help agencies replicate some of all of the HOME Project intervention.

- Production of journal and newsletter articles, conference presentations, online announcements, and other tools to disseminate information on the intervention and encourage and support program replication.

Project Logic Model: Please see **Attachment 7.**

Sustaining the Intervention: The rapidly shifting healthcare environment creates a strong range of opportunities to ensure long-term continuation of some or all of the elements of the HOME Project intervention following the conclusion of the SPNS funding period. Continuation of successful services is a key goal of the San Francisco Department of Public Health, and the project will make every effort to integrate successful aspects of the program into ongoing care and support systems in San Francisco. Among the potential opportunities that hold strong promise for project continuation are the following:

- A growing awareness of the importance of homeless HIV health needs within the overall continuum of care in San Francisco, accompanied by an expanding emphasis on the need to stabilize and house HIV-positive homeless persons to decrease mortality and minimize a key vector of HIV transmission in the city;
- Implementation of the Affordable Care Act (ACA) in January 2014, with its expansion of Medicaid benefits to a significantly expanded population of low-income individuals, including homeless persons; and
- Continued implementation of chronic care, patient registry, and coordinated team care models in San Francisco - approaches which are expected to produce greater efficiencies in care, in turn expanding the system's potential to effectively serve its most highly vulnerable populations.

WORK PLAN - See **Attachment 8.**

RESOLUTION OF CHALLENGES

Although San Francisco has been hard-hit by HIV since the earliest days of the epidemic, the city has also benefited by having in place a network of programs to help homeless persons with HIV address behavioral health needs, access supportive housing, and obtain long-term HIV treatment and care. This network has been made possible in part by the broader, longstanding commitment of the City and County of San Francisco to provide public support for direct healthcare, housing, and social services for low-income and underserved populations, a commitment that has made possible a parallel network of support services for homeless, low-income, and marginalized populations. While there remain specific gaps particularly in regard to linking and retaining multiply diagnosed HIV-positive homeless persons in care and housing, the complex referral and service network that exists in our city will provide us with access to complementary resources that will both help ensure the success of our intervention while allowing us to devote a greater share of SPNS funding to launching and testing an innovative community-based medical home model to increase homeless engagement and retention in HIV care.

At the same time, by being administratively situated within the San Francisco Department of Public Health's Community Oriented Primary Care Program - whose director also oversees San Francisco HIV Health Services - our program will benefit from unparalleled access to a range of complementary resources to support clients in our program. Through Dr. Deborah Borne, the project's in-kind Principal Investigator, the project will also ensure that the HOME Project is fully integrated with emerging healthcare reform paradigms and approaches. Our program will also benefit from the extensive public and private partnerships it will utilize to both ensure service access for homeless persons with HIV and to ensure long-term tracking and retention in care both during and following the SPNS grant term.

While the above assets provide a strong foundation for success, potential challenges exist in relation to any new initiative. Because our program is developing a **new model** to reach out, engage, stabilize, and house a highly complex and vulnerable population that has thus far resisted attempts to engage it in long-term HIV care, there is much we do not know about the ways in which our project will be successful and the ways in which it will need to be modified and adapted to achieve its goals. The expertise of our project planning team - based on years of developing and implementing successful homeless outreach and support programs - has produced a multidisciplinary team model that we believe has the best chance of success in reaching and service the target population. But our project has yet to work out specific systems and procedures for dividing work responsibilities, continually contacting clients, providing direct linkage support to ensure access to medical, behavioral health, and supportive services, and ensuring that homeless individuals develop a relationship with the **entire project team** as opposed to one individual. The project also has not begun the work of **practice learning** through which it will identify the trial and error the best methods for coordinating its services with the larger framework of homeless and HIV support services in San Francisco. Our project may discover after two or three years, for example, that the professional structure of the multidisciplinary team itself needs to change over time, or that specific work responsibilities need to be modified to achieve greater rates of success. The project may also learn that different strategies for housing the team members or ensuring inter-group communication needs to be altered.

Ultimately, it will be our attitude of **flexibility and openness to change** that will give the HOME Project its greatest possible chance of developing a successful, replicable model for reaching and engaging the most extreme and difficult to serve homeless populations with HIV in care. By continually collecting and assessing project data, identifying successes and shortfalls in the system, and maintaining an open attitude in regard to alternate approaches that may prove more successful, the HOME Project will be able to develop the optimal client support models that prove to be of greatest value in permanently changing the lives of project clients. Additionally, by working in concert with HRSA staff and by learning from other SPNS grantees through the national multi-site evaluation, the project will continually gather important new ideas for enhancing and refining our intervention. In this sense, the five-year grant period provided by the SPNS program also increases our chances of success, by giving us sufficient time to test slightly different versions of our intervention if needed in order to arrive at an intervention that can be effectively replicated in cities and jurisdictions throughout the US.

EVALUATION CAPACITY

Willingness to Participate in Multi-Site Evaluation: The HOME Project is strongly committed to cooperating and working in close partnership with the contracted Evaluation and Technical Assistance Center (ETAC) throughout the proposed SPNS initiative. We understand that this collaboration will include but is not limited to data collection and reporting of outcome, process, and cost data for the multi-site evaluation and additional focused evaluation studies. The collaboration will also include publications and other strategies to disseminate the initiative's findings and lessons learned at the national, state, and local levels. Our project also agrees to submit proof of IRB approvals and renewals for all client-level data collection instruments, informed consents, and evaluation materials to SPNS and to ETAC on at least a national basis.

Prior Experience in Multi-Site Evaluations: As the recipient of numerous SPNS and SAMHSA grants, the San Francisco Department of Public Health has extensively participated in prior multi-site evaluations, and is fully capable of working in concert with the ETAC to design outcome evaluation measures and continually collect and report multi-site data. The project's Principal Investigator, Deborah Borne, MD, has a strong research and evaluation background, and has published in peer-reviewed journals in relation to project findings (see biosketch in **Attachment 5**). The Department's overall approach to collaboration and integrated care also gives us extensive experience in participating in team-based working groups and planning settings and in generating products and findings to benefit the larger participant group.

Local Evaluation Tools, Outcome Measures, and Processes: The HOME Project will implement a comprehensive **local evaluation plan** to assess the quality, impact, and effectiveness of the proposed multidisciplinary team-based intervention. The project evaluation will include assessment of **qualitative, client-level outcome indicators** related to factors such as engagement and retention in HIV care and housing, patient health outcomes, mental health and substance abuse stabilization, and quality of life enhancements, as developed and identified in collaboration with HRSA. The project will also assess **quantitative process service data** including information on demographics of patients served, total service units provided in specific care categories, total client encounters, and other factors relevant to the program.

Many or all of the indicators in both of these categories are expected to be tracked as part of the national cross-site evaluation, using indicators and procedures developed by the Evaluation and Technical Assistance Center (ETAC). All evaluation findings will be reported and analyzed on an ongoing basis to identify areas for project improvement and to suggest specific program enhancements and refinements that can be implemented during the SPNS grant period. All clients participating in the SPNS initiative will sign IRB-approved patient consent forms and the project will place the highest possible emphasis on ensuring the protection of client data, including de-linking project data with information that could identify specific clients.

In addition to the broadly general program evaluation functions initiated in conjunction with the ETAC, our project will also select **two or more specific indicators particular to our local homeless population** that we will find appropriate to assess and evaluate. These local indicators will be developed by the PI and Project Management Team working in collaboration with SPNS and ETAC staff, and will be selected based on a set of criteria that include relevance and applicability to our local homeless population and feasibility as evaluation topics.

A unique aspect of our data collection approach involves the utilization of **citywide chronic disease registries** which will not only allow us to track client-level data during the SPNS grant period but on an ongoing basis following the conclusion of the grant program. These registries - particularly the County's Coordinated Case Management Data System (CCMS) will track both standard medical / physical health indicators such as viral load, retention in care, and attendance at medical, dental, and mental health appointments as well as **social indicators** that measure quality of life and level of stability achieved. The client data contained in these registries will be available to our project team **continually**, and in frequent data reports, and will also be available consumers (modified as a client health report as part of meaningful use), and to clinical supervision staff. Client registry data will also be used in case conferencing to serve as a driver for patient prioritization.

The CCMS system will also incorporate the **Coordinated Care Document**, a health reform mandate which serves as a kind of combined treatment plan between providers. Case histories of HOME Project clients will begin with this document and then be added to by the team over the course of the intervention. CCMS will in this context act as a conduit between medical, case management, and behavioral health information, incorporating data on utilization of emergency medical services, hospitals, shelters, and jail usage. The CCMS will also incorporate the standardized **Vulnerability Index** which HOME Project team members will utilize to help assess homeless impacts and risks.

Sample **process objectives** expected to be measured through the HOME Project include the following:

Multidisciplinary Care Management:

- An average of **20 - 25** HIV-positive homeless individuals with multiple co-morbidities who are not in care will receive an average of between 4 and 5 months of intensive management by the multidisciplinary team beginning in early 2013.
- A total of **250** unduplicated HIV-positive homeless individuals with multiple co-morbidities who are not in care will receive intensive management by the multidisciplinary team during the SPNS grant period.
- **98%** of project clients will receive a comprehensive health and psychosocial assessment by the multidisciplinary team and resulting in creation of an individualized care plan to guide the intensity and course of team-based interventions.

Linkage to Medical Care:

- At least **90%** of project clients will be linked to a patient-centered, culturally competent HIV medical home appropriate to their specific needs, conditions, and cognitive and physical status within two months of engagement with the multidisciplinary team.

Residential Stability:

- At least **65%** of project clients will be successfully housed in long-term and supportive housing over the course of the SPNS grant period.
- **100%** of new tenants placed through the HOME Project will enroll in third-party rent payment services prior to lease signing and move-in to ensure timely rent payment.

Behavioral Health Engagement:

- At least **75%** of clients with a psychiatric diagnosis will have seen a psychiatrist and will be on a monitored psychotropic regimen within three months of engagement with the multidisciplinary team.
- At least **50%** of chronic substance users will be enrolled in a medical substance abuse treatment plan within three months of engagement with the multidisciplinary team.
- A baseline substance abuse questionnaire will be completed for **98%** of the clients enrolled in the program.

Sample Home Project **outcome objectives** include the following::

Linkage to Medical Care:

- At least **90%** of project clients who have been linked to a patient-centered, culturally competent HIV medical home through the program will remain engaged in medical home treatment by the conclusion of the SPNS grant period.
- Project clients will demonstrate a combined **50%** reduction in emergency room and urgent care center visits as compared to rates at baseline.
- Project clients will demonstrate a combined **50%** reduction in hospital inpatient stays as compared to rates at baseline.

Residential Stability:

- At least **85%** of project clients who have been successfully housed in long-term and supportive housing will remain in housing by the conclusion of the SPNS grant period.

Behavioral Health Engagement:

- At least **85%** of clients with a psychiatric diagnosis will remain in psychiatric care and treatment by the conclusion of the SPNS grant period.
- Project clients will demonstrate a combined **50%** reduction in incarceration episodes and a **75%** reduction in incarceration days as compared to rates at baseline.
- Project clients will demonstrate a combined **50%** reduction in annual psychiatric emergency visits as compared to rates at baseline.
- Project clients will demonstrate a combined **50%** reduction in annual inpatient psychiatric hospital episodes and a **50%** reduction in annual inpatient psychiatric hospital days as compared to rates at baseline.

Prior Local Evaluation Expertise: As one of the nation's largest public health systems, the San Francisco Department of Public Health is highly qualified to oversee the proposed SPNS initiative and to ensure a professional, comprehensive, and effective evaluation process. The specific divisional unit responsible for the proposed SPNS grant - the Department's Community Oriented Primary Care Program (COPC) - encompasses a network of 12 large-scale public FQHC clinics specifically focused on the health needs and communities in which they are based,

and maintains and oversees numerous grants and contracts that incorporate extensive evaluation components. Additionally, medical standards within the COPC program require strong data reporting capabilities along with extensive systems for protecting and ensuring the confidentiality of patient data.

The San Francisco Department of Public Health has received and successfully evaluated numerous SAMHSA grants including the following:

- SAMHSA, Grant # 4 H79 TI12667-03-2, Action Point Grant
- SAMHSA, Grant # 5 H79 SM55886-02, Chronic Homeless Initiative
- SAMHSA, Grant # 1 H79 SM56019-01, Expanding Supportive Housing Services to Homeless
- SAMHSA, Grant # 1 H79 SM56819-01, Supportive Housing for Chronically Homeless People
- SAMHSA/CSAT Grant # 4 TI 14035-03-2, Behavioral Health in Supportive Housing

The Department has also evaluated previous Special Projects of National Significance grant programs, including a grant in collaboration with the University of California San Francisco which evaluated dispensation of buprenorphine treatment for HIV patients at their primary medical care site. Many of the clients initially engaged in that program as long as seven years ago are still engaged in buprenorphine treatment.

More recently the Department of Public Health oversaw and evaluated the complex **The Homeless Children's Mental Health Initiative**, representing a partnership between the San Francisco Department of Public Health's Child, Youth, and Family System of Care, community-based agencies providing shelter and housing to homeless families, and community-based providers of mental health services to young children. The aim of the Initiative was to provide mental health services to children birth through five years of age and their families residing in 11 homeless shelters, domestic violence shelters, and transitional housing programs. To implement services, the Department contracted with **six** providers of shelter and transitional housing services. Each agency evaluated their existing program needs and used project funds to enhance their ability to provide on-site mental health services. An evaluation was designed to examine how initiative services were incorporated into the various programs, and how mental health services through the initiative served the needs of families with children five years of age or younger. The evaluation plan included both quantitative and qualitative components, with the quantitative component focusing on children, parents, and shelter/ housing staff being served by the initiative and the qualitative component providing a deeper insight into the life experiences of families with young children living in a shelter environment, and exploring the effectiveness of the various models of services implemented.

The project's in-kind **Principal Investigator, Deborah Borne, MD**, also has research and evaluation experience and is an expert in utilizing and applying countywide patient registry systems to track and analyze client-level data. Dr. Borne currently serves as Clinical Director of Integration for both the Community Behavioral Health Services and Prevention Divisions of the San Francisco Department of Public Health, overseeing the complex integration of homeless, medical, and behavioral health systems and tracking within those two units, including integrating planning for healthcare reform. Dr. Borne also currently works with the applicant sub-unit for the current SPNS grant, Community Oriented Primary Care (COPC), as well as the project's key medical provider, the Tom Waddell Health Center. For COPC, Dr. Borne oversees the HIV

program in terms of quality improvement, clinical care, and grants and care coordination. At Tom Waddell Health Center, Dr. Borne serves as Medical Director for Homeless and Community Programs, overseeing all homeless health policy, community integrated programs such as the Tenderloin Center of Excellence, and shelter health and wellness programs. Dr. Borne began her career in research and evaluation of HIV and homeless programs and served as Project Director for a National Institute of Drug Abuse (NIDA) program from 1991 to 1995. The project was geared to HIV and substance use relapse prevention for positive and high risk negative women coming out of Rikers Island Prison in NYC. Participants were tracked for 18 months post intervention and showed had an **80%** follow-up. In addition to several presentations for this project at three international AIDS conferences, Dr. Borne has authored many publications, including on the influential **critical time intervention (CTI)** model which grew of a groundbreaking McKinney grant.

Identification of Institutional Review Board: To ensure client safety and study integrity, the HOME Project will contract with **Ethical & Independent Review Services (E&I)** to perform Institutional Review Board (IRB) functions for the program. E&I is the relatively recent product of a merger between Independent Review Consulting (IRC) and Ethical Review Committee (ERC), the former of which served as the IRB of record for past San Francisco grant programs such as the HRSA SPNS Tenderloin Oral Health Collaborative. With over **45 years** of combined experience, E&I provides prompt, high quality reviews of research on behalf of subject safety. Our project will work with E&I to obtain approvals and renewals for all client-level data collection instruments, informed consents, and evaluation materials. We will also submit these approvals and renewals on an **annual basis** to both the ETAC and the SPNS program.

Participation in Human Subjects Protection Training: All HOME Project staff will undergo training and receive certification in human subjects protection via the widely respected online training course **Protecting Human Research Participants** developed by the NIH Office of Extramural Research (phrp.nihtraining.com/users/login.php).

Safeguarding Patient Privacy and Confidentiality: Our project is strongly committed to cooperating and working in close partnership with both SPNS staff and the ETAC to protect the privacy and confidentiality of study participant medical records and other client-level data. As highly respected human service agencies with unblemished track records in relation to the protection of client data and records - including in regard to grant programs with extensive evaluation components - both the Tom Waddell Health Center and Asian & Pacific Islander Wellness Center are expert in ensuring the protection of client data. Both agencies maintain password-protected computer systems and locked client files that are accessible only to authorized staff with computer passwords being changed at least quarterly. Additionally, throughout most of the project evaluation process, identifying data such as names or social security numbers will be **de-linked** from patient-level data collected in relation to the project evaluation, with patients instead identified using a unique identifier to be developed by the Principal Investigator.

ORGANIZATIONAL INFORMATION

Overview of Participating Agencies: The proposed grantee agency for SPNS HOME Project initiative will be the **San Francisco Department of Public Health,** whose mission is to protect and improve the health and quality of life for all San Franciscans. As one of the nation's largest public health agencies, the Department successfully oversees hundreds of contracts to ensure the delivery of high-quality, culturally and linguistically competent care to a wide range of impoverished, underserved, and high need populations. The Department's HIV Health Services unit, for example - a unit that is overseen by our proposed Project Administrator, Bill Blum - manages over 70 HIV medical and social service contracts through an annual total of $20.4 million in Ryan White Part A funding, $3.2 million in Part B funding, $634,000 in Minority AIDS Initiative funding, and $704,000 in San Francisco General Fund support. The primary Departmental agency unit for the proposed program will be the **Community Oriented Primary Care (COPC)** section, encompassing a network of **12** large-scale public FQHC clinics specifically focused on the health needs and communities in which they are based, and maintaining numerous grants and contracts that incorporate extensive evaluation components.

A high percentage of medical services for the program will be provided by the Department's **Tom Waddell Health Center (TWHC),** which will also house the project's 20% time Psychiatric Registered Nurse. TWHC is a FQHC-qualified, community-based facility that provides care to the most highly disadvantaged populations in the Tenderloin neighborhood of San Francisco. Founded in the late 1980s, the Center grew out of the community health movement, and was designed to address needs specific to the hard-hit neighborhood in which it was intentionally based. The mission of the Center is to provide comprehensive health care for homeless people and for other severely underserved individuals in the community.
Both the Health Center and the Department of Public Health utilize a harm reduction philosophy of care whose aim is to optimize patient health and functioning while assisting them to reduce harm in their daily lives.

Tom Waddell Health Center currently provides care to nearly **9,000** residents of supportive housing in San Francisco per year, nearly all of them individuals coping with mental health diagnoses and substance abuse issues. Health care at the Center is delivered through a comprehensive, multidisciplinary team. The Center ensures that at least three dedicated clinicians are on site during all office hours, including a Physician, a Physician Assistant, and a Nurse Practitioner. The Center is also staffed by a dedicated transgender Clinic Charge Nurse, two Medical Social Workers, a full team of Registered Nurses, and a full team of additional support staff, including MEAs, phlebotomists, registration staff, et cetera. Languages spoken by clinic staff include English, Spanish, Korean, and Italian, with other language interpreters available by phone through the Health Department's citywide interpretations service.

The Center has a specialty in providing health care for the homeless, including through an upcoming merger with the city's only **Housing and Urban Health Clinic**. Services provided through the Clinic include primary linked medical and psychiatric care; substance abuse counseling and detox referral; HIV and STD screening and treatment; health education; GYN services; medication adherence; and phlebotomy. The Housing Clinic also incorporates Action Point, an HIV medication adherence initiative that also assesses and addresses housing retention and related areas.

Asian & Pacific Islander Wellness Center, our project's non-profit community partner and the subcontracted agency at which our two project MSWs and Homeless Peer Navigators

will be based, was also founded in the late 1980s, specifically as a grassroots response to the crisis of HIV/AIDS in the Asian / Pacific Islander community. The agency has since evolved to become a multi-cultural health services, prevention education, research, and public policy and advocacy organization with decades of experience serving communities of color and homeless persons. Services in San Francisco include a free medical clinic, HIV care, HIV/STD and hepatitis B/C testing, health education, and health promotion events. APIWC also builds HIV prevention capacity in organizations and communities of color through capacity building trainings and technical assistance. The agency features a robust Health Services program and a vital Community Development and External Affairs program. The agency's Health Services programs include:

- Health Education programming, including HIV and hepatitis prevention and testing for queer or questioning youth, gay and bisexual men, and transgender persons.
- TRANS:THRIVE, a program for transgender individuals that offers drop-in services, educational workshops, social groups, case management, HIV education and testing, STD screening, substance abuse and mental health counseling, and employment skills development for transgender persons of color.
- The HIV Care program, which provides case management, mental health and substance abuse counseling, on-site primary medical and psychiatric care, and other services for persons living with HIV, and serves as the sole HIV care provider in the Tenderloin district of San Francisco.
- A newly opened Wellness Clinic providing free primary medical care to low-income, uninsured A&PIs and the LGBTQ community. The Wellness Clinic is a major addition to the on-site primary medical care services that have been provided to HIV-positive individuals at the site, representing an expansion into preventive care to HIV-negative individuals.

Meanwhile, the agency's Community Development and External Affairs program includes:

- Technical assistance to build HIV prevention capacity in organizations and communities throughout the United States and its Pacific Territories; conduct community-based research; and train non-medical service providers throughout California in HIV treatment, funded for the past decade through The California Department of Health Services, Office of AIDS Statewide Training and Education Program (CSTEP).
- A Social Marketing program that fights HIV-related stigma in A&PI communities through health promotion and advertising campaigns, including leading the nationally-endorsed A&PI HIV/AIDS Awareness Day held annually on May 19.
- A Public Policy and Advocacy program that works to increase access to care for A&PIs, especially high-risk A&PIs and those living with HIV, with a focus on health care reform, San Francisco Department of Health Services FY 2012 Transgender Women of Color SPNS Application immigration, funding for HIV prevention and care, and the Obama Administration's new National HIV/AIDS Strategy.

As noted above, the **SF HOT Team** at which the full-time Homeless Outreach Worker will be based is an ambitious public / private partnership involving the non-profit Community Access and Treatment Services, Inc. (CATS), the San Francisco Department of Public Health, and the San Francisco Human Services Agency (HSA). The program involves **85** staff who actively

outreach and engage people living in the streets and shelters and controls approximately **274** stabilization units that can move people off the streets into basic housing in less than 24 hours. SF HOT carries a caseload of **943** clients and has a median length of time of service of **18 months**. By basing the HOME Project's Homeless Outreach Worker within the SF HOT program as a whole, the Outreach Worker will be able to coordinate care and outreach to target the most difficult "outliers" among HIV-positive, out of care homeless populations in the city. At the same time, the SPNS-funded Outreach Worker will expand expertise through association with the SF HOT team that he or she can bring to the HOME Project team. The close relationship between SF HOT and out Homeless Outreach Worker will also ensure a seamless transition when clients are either moved off or moved onto the HOME Project caseload.

The **Forensic AIDS Project (FAP)** - providing transitional support to clients entering or leaving the San Francisco jail system - is a program of Jail Health Services, the division of the San Francisco Department of Public Health responsible for providing healthcare to incarcerated men and women in the San Francisco county jails. FAP was created in the early 1980's and is the first such program in the state of California to offer HIV/AIDS education to county jail prisoners. In the late 1980s FAP began distributing condoms to prisoners and in 1992 FAP's services expanded from health education to include HIV testing and early intervention HIV services, offering both primary care and case management to HIV positive prisoners while incarcerated. FAP currently sees approximately 600 to 700 unduplicated HIV-positive prisoners a year for primary care, discharge planning and case management services, and offers follow-up and support services for up to 90 days of post release. 69% of these 600 incarcerated men and women primarily live in unstable housing.

Evaluation Capacity: As noted above, the HOME Project will implement a comprehensive local evaluation plan to assess the quality, impact, and effectiveness of the proposed multidisciplinary team-based intervention. The project evaluation will include **qualitative assessment** of client-level outcome indicators related to factors such as engagement and retention in HIV care and housing, patient health outcomes, mental health and substance abuse stabilization, and quality of life enhancements, as developed and identified in collaboration with HRSA. The project will also assess **quantitative, process-related service data** including information on demographics of patients served, total service units provided in specific care categories, total client encounters, and other factors relevant to the program. The project will also participate closely in the Evaluation and Technical Assistance Center (ETAC) component of the project.

As one of the nation's largest public health departments, SFDPH has unparalleled experience in deploying and managing complex, multidisciplinary projects and in designing effective evaluation strategies to assess these programs' impact and effectiveness. The Department has successfully evaluated numerous SPNS and SAMHSA grants, and has developed and disseminated effective tools and strategies to share project findings. The project's in-kind Principal Investigator, Dr. Deborah Borne, also has extensive evaluation experience and has produced numerous publications and presentations related to evaluation results.

Project Organizational Chart - See **Attachment 10**

Technical Assistance Needs: At this time, the HOME Project does not anticipate having specific technical assistance needs in relation to the design, implementation, and evaluation of

the project. New staff hired through the program will receive extensive training and orientation utilizing established, effective protocols in use within the San Francisco Department of Health Services.

Cultural and Linguistic Competency: Successfully working with HIV-positive homeless populations in any health care context demands a strong degree of cultural and linguistic competency on the part of staff and volunteers. This includes not only being able to address the needs of ethnically and gender diverse population, but also being able to sensitively work with mentally and physically disabled clients, active substance users, clients who have experienced sexual assault and/or violence, and clients who have been involved in the criminal justice system. Program staff need to understand that the experience of being homeless and the survival strategies it engenders can lead to increased fear, hyper-vigilance, and suspicion on the part of clients. Homeless populations have been labeled as "hard to reach," yet because many are often living and working on the street they can ironically also be one of the most visible. The primary barrier to reaching the homeless population is not locating them, but forming **trust relationships** and making **consistent contact over time** to promote behavior change and engagement and retention in care.

All of our project partners have extensive experience and are recognized experts and national leaders in the provision of culturally competent health services to homeless persons living with HIV. As noted in the application narrative, Tom Waddell Health Center provides comprehensive HIV medical home services specifically for homeless persons and for persons housed in publicly funded supportive and shelter programs. The Center also provides specialized medical services for persons with severe and persistent mental illness, including patients who would not be permitted to receive care at any other medical facility. Meanwhile, Asian & Pacific Islander Wellness Center operates **California Statewide Training & Education Program (CSTEP)** - a program that sets the standard in HIV treatment and public benefits education for providers.

ENDNOTES

[1] The White House Office of National AIDS Policy, *National HIV/AIDS Strategy for the United States,* Washington, DC, July 2010, www.whitehouse.gov/on

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1. DATE ISSUED: 08/28/2012	2. PROGRAM CFDA: 93.928	
3. SUPERSEDES AWARD NOTICE dated: except that any additions or restrictions previously imposed remain in effect unless specifically rescinded.		
4a. AWARD NO.: 1 H97HA24966-01-00	4b. GRANT NO.: H97HA24966	5. FORMER GRANT NO.:
6. PROJECT PERIOD: FROM: 09/01/2012 THROUGH: 08/31/2017		
7. BUDGET PERIOD: FROM: 09/01/2012 THROUGH: 08/31/2013		

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

NOTICE OF AWARD
AUTHORIZATION (Legislation/Regulation)
Public Health Service Act, Title XXVI, Section 2618a
Section 2691 of the Public Health Service (PHS) Act, (42 U.S.C. 390ff-101)
Section 2691 of the Public Health Service Act, 42 U.S.C. § 300ff-101
Public Health Service Act, Section 2691 (42 USC 300ff-101), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87)
Public Health Service Act; Section 2691 (42 USC 300ff-101), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87)
Public Health Service Act, Title XXVI, Section 2691 (42 U.S.C. 300ff-101), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L 111-87)

8. TITLE OF PROJECT (OR PROGRAM): Special Projects of National Significance

9. GRANTEE NAME AND ADDRESS:	10. DIRECTOR: (PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR)
CITY & COUNTY OF SAN FRANCISCO 1380 Howard St San Francisco, CA 94103-2638 DUNS NUMBER: 103717336	Bill Blum CITY & COUNTY OF SAN FRANCISCO 1380 Howard Street San Francisco, CA 94103-2614

11. APPROVED BUDGET: (Excludes Direct Assistance)

[X] Grant Funds Only

[ ] Total project costs including grant funds and all other financial participation

a. Salaries and Wages :	$0.00
b. Fringe Benefits :	$0.00
c. Total Personnel Costs :	$0.00
d. Consultant Costs :	$0.00
e. Equipment :	$0.00
f. Supplies :	$0.00
g. Travel :	$0.00
h. Construction/Alteration and Renovation :	$0.00
i. Other :	$300,000.00
j. Consortium/Contractual Costs :	$0.00
k. Trainee Related Expenses :	$0.00
l. Trainee Stipends :	$0.00
m. Trainee Tuition and Fees :	$0.00
n. Trainee Travel :	$0.00
o. TOTAL DIRECT COSTS :	$300,000.00
p. INDIRECT COSTS (Rate: % of S&W/TADC) :	$0.00
q. TOTAL APPROVED BUDGET :	$300,000.00
i. Less Non-Federal Share:	$0.00
ii. Federal Share:	$300,000.00

12. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE:

a. Authorized Financial Assistance This Period	$300,000.00
b. Less Unobligated Balance from Prior Budget Periods	
i. Additional Authority	$0.00
ii. Offset	$0.00
c. Unawarded Balance of Current Year's Funds	$0.00
d. Less Cumulative Prior Awards(s) This Budget Period	$0.00
e. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	$300,000.00

13. RECOMMENDED FUTURE SUPPORT: (Subject to the availability of funds and satisfactory progress of project)

YEAR	TOTAL COSTS
02	$300,000.00
03	$300,000.00
04	$300,000.00
05	$300,000.00

14. APPROVED DIRECT ASSISTANCE BUDGET: (in lieu of cash)

a. Amount of Direct Assistance	$0.00
b. Less Unawarded Balance of Current Year's Funds	$0.00
c. Less Cumulative Prior Awards(s) This Budget Period	$0.00
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	$0.00

15. PROGRAM INCOME SUBJECT TO 45 CFR Part 74.24 OR 45 CFR 92.25 SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:

A=Addition B=Deduction C=Cost Sharing or Matching D=Other [A]

Estimated Program Income: $0.00

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY HRSA, IS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:

a. The grant program legislation cited above. b. The grant program regulation cited above. c. This award notice including terms and conditions, if any, noted below under REMARKS. d. 45 CFR Part 74 or 45 CFR Part 92 as applicable. In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS: (Other Terms and Conditions Attached [X]Yes [ ]No)

Electronically signed by Brad Barney , Grants Management Officer on : 08/28/2012

17. OBJ. CLASS: 41.45	18. CRS-EIN: 194600417B2	19. FUTURE RECOMMENDED FUNDING: $0.00

According to the CCR Website, it can take 24 hours or more for updates to take effect. Recipients may view the CCR Registration Status by visiting https://www.bpn.gov/CCRSearch/Search.aspx and searching by their organization's DUNS. The CCR website provides user guides, renewal screen shots, FAQs and other resources you may find helpful.

Important Notice: The General Services Administration will be moving CCR to the System for Award Management (SAM) at the end of July 2012. HRSA strongly recommends that all recipients (and subrecipients) visit CCR prior to this change to verify the status of their accounts. To learn more about the switch from CCR to SAM, you can get more information at https://www.bpn.gov/ccr/NewsDetail.aspx?id=2012&type=N. To learn more about SAM, visit SAM.gov.

Reporting Requirement(s)

1. **Due Date: Within 90 Days of Project End Date**
   A final report is due within 90 days after the project period ends. Further information on specific content will be provided post-award.

2. **Due Date: 03/15/2013**
   Grantees are required to submit semi-annual progress reports at the time and in the format specified by the HRSA SPNS program.

3. **Due Date: 01/30/2014**
   The grantee must submit a Federal Financial Report (FFR) no later than January 30, 2014. The report should reflect cumulative reporting within the project period and must be submitted using the Electronic Handbooks (EHBs).

Failure to comply with these reporting requirements will result in deferral or additional restrictions of future funding decisions.

Contacts

NoA Email Address(es):

Name	Role	Email
Bill Blum	Program Director	bill.blum@sfdph.org

Note: NoA emailed to these address(es)

Program Contact:

For assistance on programmatic issues, please contact Pamela Belton at:
MailStop Code: 7C-07
HRSA/HAB
5600 Fishers Ln
Rockville, MD, 20852-1750
Email: pbelton@hrsa.gov
Phone: (301) 443-4461
Fax: (301) 594-2511

Division of Grants Management Operations:

For assistance on grant administration issues, please contact Beverly Smith at:
MailStop Code: 15-19
HRSA/OFAM /DGMO/HRB
5600 Fishers Ln
RM 15-19
Rockville, MD, 20852-0001
Email: bsmith@HRSA.GOV
Phone: (301) 443-7065
Fax: (301) 443-9810

FY-CAN	CFDA	DOCUMENT NO.	AMT. FIN. ASST.	AMT. DIR. ASST.	SUB PROGRAM CODE	SUB ACCOUNT CODE
12 - 3777200	93.928	H97HA24966A0	$300,000.00	$0.00		N/A

HRSA Electronic Handbooks (EHBs) Registration Requirements

The Project Director of the grant (listed on this NoA) and the Authorizing Official of the grantee organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the 10-digit grant number from box 4b of this NoA. After you have completed the initial registration steps (i.e.,created an individual account and associated it with the correct grantee organization record), be sure to add this grant to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit https://grants.hrsa.gov/webexternal/login.asp to use the system. Additional help is available online and/or from the HRSA Call Center at 877-Go4-HRSA/877-464-4772.

Terms and Conditions

Failure to comply with the special remarks and condition(s) may result in a draw down restriction being placed on your Payment Management System account or denial of future funding.

Grant Specific Condition(s)

1. **Due Date: Within 30 Days of Budget Start Date**

   Specify in-kind level of effort of Carlos Bermudez, Director of Health Services for A&PI Wellness Center, and Dr. Deborah Borne, Clinical Director of Homeless and Community Based Programs, Integration, and HIV Care for San Francisco Department of Public Health for their participation in the proposed Project Management Team.

2. **Due Date: Within 30 Days of Budget Start Date**

   Provide complete Curriculum Vitae for proposed Principal Investigator, Dr. Royce Lin, to include previous publications per Objective Review Committee Summary Statement.

3. **Due Date: Within 30 Days of Budget Start Date**

   Submit a revised SF 424A, Line Item Budget, and Budget Narrative Justification, in accordance with the application guidance reflecting the Federal share of $300,000 : a. clarify level of effort inconsistency for the two Transgender Outreach Workers / Navigators between justification narrative(1.8) and line item (1.6). b. correct math error in calculating per diem travel costs and adjust budget elsewhere as necessary.

Grant Specific Term(s)

1. Acceptance of this award indicates a grantee's agreement to participate in all aspects of the multi-site evaluation and communicate with the Evaluation and Technical Assistance Center (ETAC). Grantees must comply with requests for data and information in accordance with specified timelines of the ETAC. Required multi-site evaluation activities includes but are not limited to:

   a. Attending two HRSA grantee meetings per year. Travel to attend HRSA grantee meetings is limited to no more than three staff participants.
   b. Reporting of core measures to be specified by the ETAC.
   c. Cooperating with the ETAC to conduct focused evaluation studies of interest to the initiative, such as exploring case studies, cost analysis (including cost-effectiveness, if feasible), impact and/or policy issues pertaining to the goals and objectives of the specific initiative.

2. Demonstration sites must obtain and submit documentation of local Institutional Review Board (IRB) approval on all evaluation and data collection instruments for both local and multisite activities. Upon expiration, submit documentation from the appropriate IRB, which indicate the project has undergone an annual review and complies with all IRB requirements.

3. Travel to attend national conferences for the purposes of disseminating Special Projects of National Significance (SPNS) findings is limited to only two such conferences per year and the grantee must be a presenter addressing SPNS supported activities. Any such conferences being supported with SPNS funding will be limited to no more than two staff participants.

4. Grantees are required to have a Program Director/Principal Investigator (PD/PI) in place within 3 months of the budget period start date. The grantee is required to notify the OPDIV in writing if the PD/PI:

   a. is not in place within the required 3 months
   b. withdraws from the project entirely
   c. is absent from the project during any continuous period of 3 months or more
   d. reduces time devoted to the project

   The requirement to obtain OPDIV prior approval for such change in status pertains to the PD/PI and those key personnel named in the award

notice regardless of whether the grantees organization designates others for its own purposes. If the arrangements proposed by the grantee, including the qualifications of any proposed replacement are not acceptable to the OPDIV, the grant may be suspended or terminated. If the grantee wants to terminate the project because it cannot make suitable alternate arrangements, it must notify the OPDIV in writing of its wish to terminate, and the OPDIV will forward closeout instructions.

5. Grantee must allocate funds to attend the Ryan White Program's All Grantee Meeting held every 2 years. The next meeting will be held in November 2012 in Washington, DC.

6. Funds under this award may not be used for the following purposes:
a. To directly provide health care or testing services that are billable to third party payers (e.g., private health insurance, prepaid health plans, Medicaid, Medicare, other Ryan White Program funding including ADAP);
b. With the exception of testing services allowable under program requirements established in the funding opportunity announcement, to directly provide health care services that duplicate existing services;
c. Purchase, construction of new facilities or capital improvements to existing facilities;
d. Purchase or improvement to land;
e. Purchase vehicles;
f. Fundraising expenses;
g. Lobbying activities and expenses;
h. Reimbursement of pre-award costs;
i. International travel; and/or
j. Cash payments to intended service recipients, as opposed to various non-cash incentives to encourage participation in evaluation activities.

2. As required by the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, recipients must report information for each subaward of $25,000 or more in Federal funds and executive total compensation as outlined in Appendix A to 2 CFR Part 170 (http://www.hrsa.gov/grants/ffata.html). Subawards to individuals are exempt from these requirements.
3. Requirements for CCR: Unless your entity is exempt from this requirement under 2 CFR 25.110, it is incumbent upon you, as the recipient, to maintain the accuracy/currency of your information in the CCR until the end of the project. Additionally, this term requires your entity to review and update the information at least annually after the initial registration, and more frequently if required by changes in your information or another award term. Requirements for DUNS numbers: If you are authorized to make subawards under this award, you : - Must notify potential subrecipients that no entity may receive a subaward from you unless the entity has provided its DUNS number to you. - May not make a subaward to an entity unless the entity has provided its DUNS number to you.

Standard Term(s)

1. All discretionary awards issued by HRSA on or after October 1, 2006, are subject to the HHS Grants Policy Statement (HHS GPS) unless otherwise noted in the Notice of Award (NoA). Parts I through III of the HHS GPS are currently available at ftp://ftp.hrsa.gov/grants/hhsgrantspolicystatement.pdf. Please note that the Terms and Conditions explicitly noted in the award and the HHS GPS are in effect.
2. The HHS Appropriations Act requires that when issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds, including but not limited to State and local governments, shall clearly state the percentage of the total costs of the program or project which will be financed with Federal money, the dollar amount of Federal funds for the project or program, and percentage and a dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.
3. Recipients and sub-recipients of Federal funds are subject to the strictures of the Medicare and Medicaid anti-kickback statute (42 U.S.C. 1320a - 7b(b) and should be cognizant of the risk of criminal and administrative liability under this statute, specifically under 42 U.S.C. 1320 7b(b) Illegal remunerations which states, in part, that whoever knowingly and willfully: (A) Solicits or receives (or offers or pays) any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring (or to induce such person to refer) an individual to a person for the furnishing or arranging for the furnishing of any item or service, OR (B) In return for purchasing, leasing, ordering, or recommending purchasing, leasing, or ordering, or to purchase, lease, or order, any goods, facility, services, or item ....For which payment may be made in whole or in part under subchapter XIII of this chapter or a State health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
4. Items that require prior approval from the awarding office as indicated in 45 CFR Part 74.25 [Note: 74.25 (d) HRSA has not waived cost-related or administrative prior approvals for recipients unless specifically stated on this Notice of Award] or 45 CFR Part 92.30 must be

submitted in writing to the Grants Management Officer (GMO). Only responses to prior approval requests signed by the GMO are considered valid. Grantees who take action on the basis of responses from other officials do so at their own risk. Such responses will not be considered binding by or upon the HRSA.

In addition to the prior approval requirements identified in Part 74.25, HRSA requires grantees to seek prior approval for significant rebudgeting of project costs. Significant rebudgeting occurs when, under a grant where the Federal share exceeds $100,000, cumulative transfers among direct cost budget categories for the current budget period exceed 25 percent of the total approved budget (inclusive of direct and indirect costs and Federal funds and required matching or cost sharing) for that budget period or $250,000, whichever is less. For example, under a grant in which the Federal share for a budget period is $200,000, if the total approved budget is $300,000, cumulative changes within that budget period exceeding $75,000 would require prior approval). For recipients subject to 45 CFR Part 92, this requirement is in lieu of that in 45 CFR 92.30(c)(1)(ii) which permits an agency to require prior approval for specified cumulative transfers within a grantee's approved budget. [Note, even if a grantee's proposed rebudgeting of costs falls below the significant rebudgeting threshold identified above, grantees are still required to request prior approval, if some or all of the rebudgeting reflects either a change in scope, a proposed purchase of a unit of equipment exceeding $25,000 (if not included in the approved application) or other prior approval action identified in Parts 74.25 and 92.30 unless HRSA has specifically exempted the grantee from the requirement(s).]

5. Payments under this award will be made available through the DHHS Payment Management System (PMS). PMS is administered by the Division of Payment Management, Financial Management Services, Program Support Center, which will forward instructions for obtaining payments. Inquiries regarding payments should be directed to: ONE-DHHS Help Desk for PMS Support at 1-877-614-5533 or PMSSupport@psc.hhs.gov. For additional information please visit the Division of Payment Management Website at www.DPM.PSC.GOV.
6. The DHHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Such reports are kept confidential and callers may decline to give their names if they choose to remain anonymous. Contact: Office of Inspector General, Department of Health and Human Services, Attention: HOTLINE, 330 Independence Avenue Southwest, Cohen Building, Room 5140, Washington, D. C. 20201, Email: Htips@os.dhhs.gov or Telephone: 1-800-447-8477 (1-800-HHS-TIPS).
7. Submit audits, if required, in accordance with OMB Circular A-133, to: Federal Audit Clearinghouse Bureau of the Census 1201 East 10th Street Jefferson, IN 47132 PHONE: (310) 457-1551, (800)253-0696 toll free http://harvester.census.gov/sac/facconta.htm
8. EO 13166, August 11, 2000, requires recipients receiving Federal financial assistance to take steps to ensure that people with limited English proficiency can meaningfully access health and social services. A program of language assistance should provide for effective communication between the service provider and the person with limited English proficiency to facilitate participation in, and meaningful access to, services. The obligations of recipients are explained on the OCR website at http://www.hhs.gov/ocr/lep/revisedlep.html.
9. This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000,as amended (22 U.S.C. 7104). For the full text of the award term, go to http://www.hrsa.gov/grants/trafficking.htm. If you are unable to access this link, please contact the Grants Management Specialist identified in this Notice of Award to obtain a copy of the Term.
10. The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. HRSA funds may not be used to pay the salary of an individual at a rate in excess of $179,700 (the Executive Level II salary of the Federal Executive Pay scale). This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts for substantive work under a HRSA grant or cooperative agreement. The salary limitation does not apply to payments made to consultants under this award although, as with all costs, those payments must meet the test of reasonableness and be consistent with institutional policy. **Your award amount will not necessarily be recalculated to adjust for necessary reductions in salaries included in your proposal. However, none of the funds in this award shall be used to pay the salary of an individual at a rate in excess of the salary limitation.** [It is important to note that an individual's base salary, per se, is NOT constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to HRSA grants and cooperative agreements.]
11. To serve persons most in need and to comply with Federal law, services must be widely accessible. Services must not discriminate on the basis of age, disability, sex, race, color, national origin or religion. The HHS Office for Civil Rights provides guidance to grant and cooperative agreement recipients on complying with civil rights laws that prohibit discrimination on these bases. Please see http://www.hhs.gov/ocr/civilrights/understanding/index.html. HHS also provides specific guidance for recipients on meeting their legal obligation under Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin in programs and activities that receive Federal financial assistance (P. L. 88-352, as amended and 45 CFR Part 80). In some instances a recipient's failure to provide language assistance services may have the effect of discriminating against persons on the basis of their national origin. Please see http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html to learn more about the Title VI requirement for grant and cooperative agreement recipients to take reasonable steps to provide meaningful access to their programs and activities by persons with limited English proficiency.
12. It is incumbent you, as the recipient, to maintain the accuracy/currency of your information in the Central Contractor Registration (CCR) at all times during which your entity has an active award or an application or plan under consideration by HRSA, unless your entity is exempt from this requirement under 2 CFR 25.110. Additionally, this term requires your entity to review and update the information at least annually after the initial registration, and more frequently if required by changes in your information. This requirement flows down to subrecipients.

Print Form

Introduction Form

By a Member of the Board of Supervisors or the Mayor

Time stamp
or meeting date

I hereby submit the following item for introduction (select only one):

☑ 1. For reference to Committee: [ ]
An ordinance, resolution, motion, or charter amendment.

☐ 2. Request for next printed agenda without reference to Committee.

☐ 3. Request for hearing on a subject matter at Committee: [ ]

☐ 4. Request for letter beginning "Supervisor [ ] inquires"

☐ 5. City Attorney request.

☐ 6. Call File No. [ ] from Committee.

☐ 7. Budget Analyst request (attach written motion).

☐ 8. Substitute Legislation File No. [ ]

☐ 9. Request for Closed Session (attach written motion).

☐ 10. Board to Sit as A Committee of the Whole.

☐ 11. Question(s) submitted for Mayoral Appearance before the BOS on [ ]

Please check the appropriate boxes. The proposed legislation should be forwarded to the following:

☐ Small Business Commission ☐ Youth Commission ☐ Ethics Commission

☐ Planning Commission ☐ Building Inspection Commission

Note: For the Imperative Agenda (a resolution not on the printed agenda), use a different form.

Sponsor(s):

Supervisor Wiener

Subject:

Accept and Expend Grant – Special Projects of National Significance Program - $300,000

The text is listed below or attached:

Resolution authorizing the San Francisco Department of Public Health to accept and expend retroactively a grant in the amount of $300,000 from the Health Resources and Services Administration to participate in a program entitled "Special Projects of National Significance Program Building a Medical Home for Multiply Diagnosed HIV Positive Homeless Populations – Demonstration Sites" for the period of September 1, 2012, through August 31, 2013, waiving indirect costs.

Signature of Sponsoring Supervisor: [ ]

For Clerk's Use Only:

121074

File No. 121074

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information (*Please print clearly.*)	
Name of City elective officer(s): Members, Board of Supervisors	City elective office(s) held: Members, Board of Supervisors

Contractor Information (*Please print clearly.*)	
Name of contractor: Asian & Pacific Islander Wellness Center	
Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. ***Use additional pages as necessary.*** 1) A&PI Wellness Center - Board of Directors: Tien Bui, Benjamin Leong, Bart Aoki, Ph.D., Sophia Chao, Mario Choi, JD, Devesh Khatu, Royce Lin, MD, Melinda Martin, Gary Murakami, Frank A. Sclafani, MFT, Laura Thomas, MPH, MPP, Jack Song, Erin C. Wilson, DrPH; (For complete list with affiliations, please see attached) 2) Lance Toma, LCSW-Executive Director (CEO and COO); Yvonne Watson, Director of Finance and Administration (CFO); 3) N/A; 4) N/A; 5) N/A.	
Contractor address: 730 Polk Street, 4th Floor, San Francisco, CA 94109	
Date that contract was approved: *(By the SF Board of Supervisors)*	Amount of contracts: $121,074 annually ($605,370 over 5 year s of grant term)
Describe the nature of the contract that was approved: A demonstration site project to create a Homeless Outreach Mobile Engagement (HOME) Project building medical homes for Multiply-Diagnosed HIV-Positive Homeless Populations in San Francisco.	
Comments: This is a five year SPNS grant (Special Project of National Significance) funded by the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA). Asian & Pacific Islander Wellness Center is a partner agency with the Department of Public Health/ HIV Health Services who serves as the grantee for this project.	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☑ a board on which the City elective officer(s) serves: San Francisco Board of Supervisors
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____
Print Name of Board

Filer Information (*Please print clearly.*)	
Name of filer: Angela Calvillo, Clerk of the Board	Contact telephone number: (415) 554-5184
Address: City Hall, Room 244, 1 Dr. Carlton B. Goodlett Pl., San Francisco, CA 94102	E-mail: Board.of.Supervisors@sfgov.org

_____ _____
Signature of City Elective Officer (if submitted by City elective officer) Date Signed

_____ _____
Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed