OMB Number: 4040-0004
Expiration Date: 12/31/2022

Application for Federal Assistance SF-424

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

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

* If Revision, select appropriate letter(s):

* Other (Specify):

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

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier: H89HA00006

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

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

* b. Employer/Taxpayer Identification Number (EIN/TIN): 94-6000417

* c. Organizational DUNS: 1037173360000

d. Address:

* Street1: 1380 Howard Street, 4th Floor
Street2:
* City: San Francisco
County/Parish:
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 94102-2638

e. Organizational Unit:

Department Name:

Division Name: HIV Health Services

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

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

Title: Director of HIV Health Services

Organizational Affiliation:

* Telephone Number: 628-206-7672
Fax Number:

* Email: bill.blum@sfdph.org

Application for Federal Assistance SF-424

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

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

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

Health Resources and Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.914

CFDA Title:

HIV Emergency Relief Project Grants

*** 12. Funding Opportunity Number:**

HRSA-21-055

* Title:

Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program

13. Competition Identification Number:

HRSA-21-055

Title:

Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program

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

Areas Affected by Project.pdf | Add Attachment | Delete Attachment | View Attachment

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

FY 2021 Ryan White HIV/AIDS Part A HIV Emergency Relief Grant Program

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: CA-12 | * b. Program/Project: CA-12

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 03/01/2021 | * b. End Date: 02/28/2022

18. Estimated Funding ($):

* a. Federal	15,739,566.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	15,739,566.00

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

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☒ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

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

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

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

☒ ** I AGREE

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

Authorized Representative:

Prefix: Ms. | * First Name: Anna

Middle Name:

* Last Name: Robert

Suffix:

* Title: Director of Primary Care

* Telephone Number: 415-505-4558 | Fax Number:

* Email: anna.robert@sfdph.org

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

Areas Affected by Project

The FY 2021 San Francisco EMA Ryan White Part A Emergency Relief Grant Program will be implemented in the following California regions:

- **Marin County**
- **San Francisco County**
- **San Mateo County**

FY 2021 SAN FRANCISCO EMA RYAN WHITE PART A PROJECT ABSTRACT

Project Title: Approaching Zero in a Time of Crisis: San Francisco EMA FY 2021 Ryan White Part A Competing Continuation Application
Applicant Name: San Francisco HIV Health Services
Address: 25 Van Ness Avenue, 8th Floor, San Francisco, CA, 94102
Project Director: Bill Blum, Director, HIV Health Services
Contact Numbers: Office: (415) 554-9105 / Fax: (415) 431-7547
E-Mail Address: bill.blum@sfdph.org / **Web Address:** www.sfhivcare.com
Total Funds Requested in Application: $15,739,566

Overview of the San Francisco EMA and the Local HIV Epidemic: The population of the San Francisco (SF) EMA is **1,906,948** including a population of **261,627** in Marin County, **889,360** in San Francisco County, and **776,252** in San Mateo County, with widely varying population densities among the three regions. **Over half** of the EMA's residents are people of color, including large Asian/Pacific Islander (**29.8%**), Latinx (**18.9%**), and African American (**4.1%**) populations. Over **42%** of EMA residents speak a language other than English at home. As of December 31, 2019, a total of **15,054** persons were living with diagnosed HIV in the SF EMA, for an EMA-wide HIV infection incidence of **798.4** cases per 100,000 persons. The HIV incidence in the city of San Francisco is **1,447.39** cases per 100,000 - the largest concentration in the nation outside of New York City. The epidemic disproportionately impacts men who have sex with men (MSM), who make up **82.7%** of all PLWH in the region, including MSM who inject drugs. Fully **62.8%** of all PLWH in the EMA are age 50 and older, most of whom are long-term survivors. Between December 2009 and December 2019, the number of persons 50 and over with HIV increased by **44.8%** while the number of PLWH 65 and older increased by **91.2%** over the last 36 months alone.

Comprehensive System of Care: Throughout the EMA, am emphasis on **high-quality, client-centered primary medical care services** is at the heart of the continuum of care, with medical case management providing individualized coordination and entry points to a range of medical and social services. In addition to major hospitals in the EMA, there are **seven** public clinics and **six** community clinics in San Francisco County, **two** public clinics in San Mateo County, and **one** public clinic in Marin County providing HIV/AIDS primary care. San Francisco's **seven Centers of Excellence** form an innovative network of HIV providers designed to involve and retain complex, hard-to-reach, and multiply diagnosed populations in care. San Francisco was one of the 16 original Title I EMAs funded by the Ryan White CARE Act in **1991** and first began receiving MAI funding in **1999**.

Viral Suppression and Other Continuum-Related Successes: The San Francisco EMA has achieved an unprecedented level of success in reducing the number of persons with HIV in the EMA who are aware of their serostatus, currently estimated at **94%.** At the same time, the EMA's viral load suppression rate of **73%** far surpasses the national average of **60%**. Through aggressive local prevention and care efforts, the number of new HIV infections in SF also continues to decrease, with only **166** new HIV cases were identified in calendar year 2019, by far the lowest 12-year total ever achieved in our region. The 166 new HIV cases in 2019 represents a decrease of **26.9%** from the **227** new HIV cases diagnosed in 2017 and a **64.8% reduction** from the **472** new HIV cases diagnosed in the city in 2009, only a decade before.

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	Attachment 1.pdf	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	Attachment 2.pdf	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	Attachment 3.pdf	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	Attachment 4.pdf	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	Attachment 5.pdf	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	Attachment 6.pdf	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	Attachment 7.pdf	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8	Attachment 8.pdf	Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10	Attachment 10.pdf	Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11	Attachment 11.pdf	Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13	Attachment 13.pdf	Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

The following attachment is not included in the view since it is not a read-only PDF file.

Upon submission, this file will be transmitted to the Grantor without any data loss.

Attachment 1.pdf

The following attachment is not included in the view since it is not a read-only PDF file.

Upon submission, this file will be transmitted to the Grantor without any data loss.

Attachment 2.pdf

Attachment 3.

San Francisco EMA FY 2021 Part A Application HIV Epidemiology Summary Table

Group / Exposure Category	New Diagnosed HIV Cases 1/1/19 - 12/31/19		Persons Living with HIV as of 12/31/19	
	Number	%	Number	%
Total	**272**	**100%**	**15,054**	**100%**
Current gender				
Female	24	8.8%	1,017	6.8%
Male	232	85.3%	13,650	90.7%
Transgender / Other Gender Identification	16	5.9%	387	2.6%
group at diagnosis or end of the yea r(years)				
0 - 12	0	0.0%	3	0.0%
13 - 17	1	0.4%	8	0.1%
18 - 24	26	9.6%	135	0.9%
25 - 44	173	63.6%	3,910	26.0%
45 - 49	22	8.1%	1,661	11.0%
50 - 59	29	10.7%	4,987	33.1%
60 - 64	14	5.1%	1,975	13.1%
65 and Over	7	2.6%	2,375	15.8%
Race / Ethnicity				
Black / African American	34	12.5%	1,889	12.5%
Latino / Hispanic	109	40.1%	3,642	24.2%
Asian / Pacific Islander	39	14.3%	1,120	7.4%
White (not Hispanic)	81	29.8%	7,810	51.9%
Other / Multiethnic / Unknown	9	3.3%	593	3.9%
Transmission category				
Male-to-male sexual contact (MSM)	177	65.1%	10,657	70.8%
Injection drug use (IDU)	15	5.5%	915	6.1%
MSM and IDU	22	8.1%	1,794	11.9%
Heterosexual contact	35	12.9%	1,057	7.0%
Mother with or at Risk for HIV (Pediatric)	0	0.0%	30	0.2%
TWSM	9	3.3%	217	1.4%
TWSM-PWID	5	1.8%	153	1.0%
Unknown risk	9	3.3%	194	1.3%
Other	0	0.0%	37	0.2%
TOTAL	**272**	**100%**	**15,054**	**100%**

Note: New diagnosed HIV cases include persons living in the SF EMA at time of diagnosis, while persons living with HIV include persons living in the SF EMA as of 12/31/19 regardless of residence at time of diagnosis.

TWSM = Trans women who have sex with men

TWSM-PWID = Trans women who have sex with men and person who injects drugs

For San Mateo and Marin counties TGA data considers trans persons' transmission category by sexual contact and does not consider IDU.

Attachment 4. FY 2021 San Francisco EMA Co-Occurring Conditions Table

Co-Factor / Co-Morbidity	Quantitative Totals	Per Capita Rates	Estimated Costs
Hepatitis C Virus	2018 SF Only Total Estimated Persons with Hep C Antibodies: **21,758** [1] 2018 SF Only Total Estimated Persons with Active Hep C Virus: **16,408** 2018 SF Only Total Estimated Persons with Active and Untreated Hep C Virus: **11,922**	SF Persons with Hep C Antibodies: **2,515.2** per 100,000 National: **1,400** per 100,000 [2] SF Persons with Active Hep C Virus: **1,896.8** per 100,000 SF Persons with Active and Untreated Hep C Virus: **1,378.2** per 100,000	Estimated annual cost to treat Hepatitis C infection in the SF EMA: **Unknown** [3]
Primary & Secondary Syphilis	2018 SF EMA cases: **635** [4] 2018 SF only cases: **544** 2018 California Cases: **7,621**	SF EMA-wide: **32.1** per 100,000 SF only: **61.3** per 100,000 California: **19.1** per 100,000	Total annual costs related to new STI infections: **$14,169, 500** [5] Total annual cost to treat new STI infections among PLWH: **$1,880,000** [6] Estimated cost to treat PLWH each year as a result of transmission facilitated through STIs: **$7,500,000** [7]
Gonorrhea	2018 SF EMA cases: **6,823** 2018 SF only cases: **5,894** 2018 California Cases: **79,397**	SF EMA-wide: **359.4** per 100,000 SF only: **664.1** per 100,000 California: **199.4** per 100,000	
Chlamydia	2018 SF EMA cases: **13,423** 2018 SF only cases: **9,505** 2018 California Cases: **232,181**	SF EMA-wide: **680.5** per 100,000 SF only: **1,070.9** per 100,000 California: **538.0** per 100,000	
Tuberculosis	2019 SF EMA cases: **179** [8] 2019 SF only cases: **105** 2019 California Cases: **2,115**	SF EMA-wide: **9.3** per 100,000 SF only: **11.8** per 100,000 California: **5.3** per 100,000 National: **2.8** per 100,000	Estimated annual cost to treat new TB infections: **$895,000** [9] Estimated annual cost to treat new TB infections among PLWH: **$50,000** [10]
Mental Illness	Estimated number of youth and adults with serious mental illness in San Francisco: **44,000** [11]	Estimated rate of serious mental illness among PLWH in SF EMA: **23,389** per 100,000	Estimated annual cost of mental health services for PLWH with

Co-Factor / Co-Morbidity	Quantitative Totals	Per Capita Rates	Estimated Costs
	Estimated number of PLWH in SF EMA with serious mental illness: **3,670** [12]	Estimated rate of overall mental health conditions among PLWH in SF EMA: **60,000** per 100,000 [13]	mental health conditions: **$18,830,000** [14]
Substance Use Disorder	Number of substance-related treatment admissions in SF 2013-2014: **7,940** [15] Estimated number of PLWH in SF EMA with substance-related issues: **6,276** [16]	Annual rate of substance-related SF treatment admissions: **911.7** per 100,000 Estimated rate of substance issues among PLWH in SF EMA: **39,998** per 100,000	Estimated annual cost of substance treatment services for PLWH seeking treatment: **$1,372,500** [17]
Homeless / Unstably Housed	SF Chronic Homeless: Approx. **1,050** [18] SF Temporary / Short-Term Homeless: Approx. **19,497** Per Year [19] Estimated Annual PLWH Homeless in SF EMA: **1,047** [20] Total SF EMA Ryan White Clients Reported as Homeless or Unstably Housed - 3/1/17 - 2/28/18 - **1,994**	Annual SF Homelessness Rate: Approx. **2,238.8** per 100,000 Combined Annual EMA-Wide Homelessness Rate Among PLWH: **7,000** per 100,000 Combined Homeless / Unstably Housed Rate Among All SF EMA Ryan White Clients: **29.6%** [21]	Estimated additional cost of care for HIV-positive homeless persons: Min. **$10,470,000** [22]
Formerly Incarcerated	Average number of unduplicated individuals arrested and incarcerated in the EMA in 2014: **17,500** [23] Number of formerly incarcerated persons in SF EMA Ryan White System, 2013 - 2015: **623** [24]	Annual EMA-wide incarceration rate: **2,815** per 100,000 Three-year PLWH incarceration rate, 2013 -2015: **3,905** per 100,000	Estimated annual cost of care for formerly incarcerated PLWH: **$15,575,000** [25]

[1] Estimates of persons with Hepatitis C in San Francisco from Facente S, et al., Estimated hepatitis C prevalence and key population sizes in San Francisco: A foundation for elimination, *PLOS ONE* 13(7), April 11, 2018, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0195575

[2] Ibid, from national NHANES Hep C seroprevalence data.

[3] Because of the high cost of Hepatitis C treatments, information is still emerging on whether and to what extent health insurance companies will cover the cost of Hepatitis C treatment and what percentage of persons with HIV living with Hepatitis C will opt to access this treatment. At the present time, a 12-week course of Salvadi treatment is $84,000 while a 12-week course of Harvoni treatment is $94,500

[4] All STI data this chart: State of California Department of Health Services, STD Control Branch, Primary and Secondary Syphilis, Gonorrhea, and Chlamydia, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2014-2018 Provisional Data, Sacramento, CA, Revised July 10, 2019.

[5] Calculation based on average of $1,000 per capita for syphilis and gonorrhea treatment combined with cost of undiagnosed and untreated syphilis and gonorrhea (635 and 6,823 new cases, respectively, in 2018) and $500 average per capita for Chlamydia treatment combined with cost of undiagnosed and untreated chlamydia (13,423 new cases in 2018) in the first year following diagnosis.

[6] Calculation based on estimated 5% of persons living with HIV becoming infected with non-HIV STI annually (n=752) at average treatment cost of $2,500 per capita, including costs of treating negative health consequences of STD among PLWH.

[7] Calculation based on a total of 30 new HIV infections per year facilitated through other STIs at an annual treatment cost of $25,000 x 10 years per person.

[8] All TB data this chart: California Department of Public Health, Tuberculosis Control Branch, Tuberculosis Cases by Year, Reporting Jurisdictions in California, 2010-2019, in Report on Tuberculosis in California, 2019, Sacramento, CA, July 2020.

[9] Calculation based on min. $5,000 treatment cost per year per TB case for 179 new cases in 2019.

[10] Calculation based on min. $5,000 treatment cost per year per TB case for estimated 10 new TB cases among PLWH in 2019.

[11] Source: San Francisco Department of Public Health, Behavioral Health, estimates prepared for FY 2016 San Francisco EMA Ryan White Part A application.

[12] Source: Mayne, T., et al., "Depressive affect and survival among gay and bisexual men infected with HIV," *Archives of Internal Medicine*, 156(19), October 1996.

[13] Estimate of 60% mental health conditions among PLWH in SF EMA includes both serious and persistent mental illness and a range of additional conditions include anxiety and depression.

[14] Calculation based on estimated $2,000 cost for mental health treatment per person x est. 9,415 PLWH in SF EMA with mental health conditions.

[15] Source: Gleghorn A, *Drug Abuse Patterns and Trends in the San Francisco Bay Area – Update: June 2014*, National Institute on Drug Abuse Community Epidemiology Work Group, Washington DC, https://www.drugabuse.gov/sites/default/files/sanfrancisco2014.pdf

[16] Estimate based on conservative estimate of 40% substance use issues among PLWH in SF EMA, including issues with alcohol and marijuana use.

[17] Calculation based on estimated $5,000 cost for substance abuse treatment per person for approximately 25% of PLWH with substance issues who seek treatment annually (n=1,375)

[18] Estimate of chronically homeless based on national estimate of 14% of all homeless being chronically homeless multiplied by total 7,499 homeless individuals identified during the biennial point in time homeless count conducted on January 26, 2017 (7,499 x 14% = 1,050). Sources: National Alliance to End Homelessness, *The State of Homelessness in America 2016*, Washington DC, 2017 and Applied Survey Research, *2017 San Francisco Homeless Count and Survey Comprehensive Report*, San Francisco, CA, 2017.

[19] Estimate of short-term homeless based on national estimate of 86% of all homeless being short-term homeless with average 4-month period of homelessness (7,499 - 1,050 chronic homeless = 6,449 short term homeless x 3 cycles per year = 19,497). Sources: National Alliance to End Homelessness, *The State of Homelessness in America 2016*, Washington DC, 2017 and Applied Survey Research, *2017 San Francisco Homeless Count and Survey Comprehensive Report*, San Francisco, CA, 2017.

[20] Calculation based on total 14,960 diagnosed persons with HIV living in the EMA with a conservative annual homelessness rate of 7% (n=1,047).

[21] Based on reported 2,113 homeless or unstably housed clients out of total 7,144 Ryan White clients in the SF EMA from March 1, 2018 - February 21, 2019.

[22] Calculation based on total 14,960 persons with HIV living in the EMA with a conservative annual homelessness rate of 7% (n=1,047) and a minimum additional cost of $10,000 to meet these individuals' annual homeless-related needs.

[23] Based on total reported jail bookings in Marin, San Francisco, and San Mateo Counties in 2014with an estimated recidivism rate of 50%.
[24] Based on service data from Forensic AIDS Project, the San Francisco EMA Center of Excellence serving formerly incarcerated PLWH.
[25] Calculation based on estimated cost of $25,000 per year to provide care for the minimum 623 formerly incarcerated persons in the SF EMA Ryan White system of care.

Attachment 5. FY 2021 San Francisco EMA Coordination of Services and Funding Table

Funding Source	2020 Budget	Core Medical Services	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-	Home Health Care	Home & Community-based Health	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services –	Supportive Services	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Facility-Based Health Care	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive	Rehabilitation Services	Respite Care	Substance Abuse Services –	Treatment Adherence Counseling	HIV Prevention	HIV Testing	PrEP & PEP Services	Other Prevention Services
Part A	$ 14,990,489		X		X	X	X		X	X	X	X		X			X		X	X	X		X	X		X	X	X								
Part A COVID	$ 488,185		X		X	X	X		X	X	X	X		X			X		X	X	X		X	X		X	X	X								
Part B	$ 2,662,614										X									X	X						X									
Part C	$ 1,100,009		X											X			X										X									
Part C COVID	$ 210,619		X											X																						
Part D	$ 514,799		X									X		X			X					X										X				
ETHE	$ 3,195,452		X									X		X								X						X						X	X	X
CDC	$ 7,008,377																										X					X		X	X	X
SAMHSA	$ 499,761																																	X		X
HOPWA	$ 603,311																						X													
MEDICAID	$80,695,334		X		X					X	X		X																							

San Francisco HIV Community Planning Council

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

August 14, 2020

Steven R. Young, MSPH
Director, Division of Metropolitan HIV/AIDS Programs
HIV/AIDS Bureau, Health Resources and Services Administration
Parklawn Building, Room 7A-55, 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Young:

As Co-Chairs of the San Francisco HIV Community Planning Council, and on behalf of the Planning Council as a whole, we are writing to provide assurance of the following procedural elements related to the FY 2021 Ryan White Part A application being submitted to HRSA by the San Francisco Department of Public Health:

- No FY 2020 Conditions of Award were related to the Planning Council and its activities, and therefore all FY 2020 Conditions of Award related to the Planning Council have been addressed;
- The Planning Council continually tracks the allocation and expenditure of Part A Formula, Supplemental, and MAI funds by the San Francisco Department of Public Health, and ensures that Part A funds awarded to the EMA are being expended according to the priorities established by the Planning Council;
- The Planning Council will utilize a collaborative planning process that incorporates a wide range of relevant data and consumer and provider input to determine FY 2021 Part A funding priorities and to establish priorities through an open voting process; and
- The most recent training for new Planning Council members took place on October 22, 2019, while the next annual Planning Council training for all Council members will take place in the fall of 2020. An additional for all Planning Council members on new HRSA mandates related to Part A funding will take place on August 24, 2020.

Thank you for your continuing support of the San Francisco region and its merged HIV Community Planning Council. We look forward to continuing our partnership to provide effective, comprehensive, and high-quality services to low-income and severely impacted persons living with HIV in our region.

Sincerely,

David Gonzalez
Community Co-Chair

Irma Parada
Community Co-Chair

Kevin Hutchcroft
Government Co-Chair

Thomas Knoble
Government Co-Chair

(415) 674-4751 730 Polk Street, 3rd Floor, San Francisco CA 94109 (415) 674-0373 fax
www.sfhivplanningcouncil.org

Attachment 7. San Francisco, California EMA FY 2021 HIV Care Continuum Table
Baseline Reporting Period: January 1 - December 31, 2019

Stages of the HIV Care Continuum	HIV Care Continuum Goal	Outcomes		Applicable Part A Funded Service Categories
I. Diagnosed	Increase in the percentage of clients who are aware of their HIV status as a percentage of all PLWH in the San Francisco EMA	HIV Positivity & Late HIV Diagnosis		▪ Early Intervention Services ▪ Outreach Services
		Baseline: **15,054 / 16,015 - 94.0%**	**FY 2021 Target:** **15,326 / 16,132 - 95.0%**	
II. Linked to Care	Increase in the percentage of clients linked to care **within 30 days** among those newly testing positive within the reporting period	Linkage to HIV Medical Care		▪ Outpatient Medical Care ▪ Early Intervention Services ▪ Medical Case Management ▪ Non-Medical Case Mgmt. ▪ Medical Transportation
		Baseline: **250 / 272 - 92.0%**	**FY 2021 Target:** **253 / 272 - 93.0%**	
III. Retained in Care	Increase in the percentage of clients retained in care among all PLWH in the San Francisco EMA	Retention in HIV Medical Care, Defined as **at Least 1 Viral Load or Genotype Test in a CY**		▪ Outpatient Medical Care ▪ Early Intervention Services ▪ Medical Case Management ▪ Medical Transportation ▪ Mental Health Services
		Baseline: **12,043 / 15,054 – 80.0%**	**FY 2021 Target:** **15,326 / 12,567 – 82.0%**	
IV. Prescribed ART	Increase in the percentage of clients with access to prescribed HIV/AIDS medications among PLWH in care in the San Francisco EMA	Antiretroviral Therapy (ART) Among Persons in HIV Medical Care & Prescription of HIV Antiretroviral Therapy		▪ Outpatient Medical Care ▪ Pharmaceutical Assistance ▪ Medical Case Management ▪ Medical Transportation
		Estimated Baseline: **11,440 / 12,043 - 95.0%**	**FY 2021 Target:** **12,064 / 12,567 – 96.0%**	
V. Virally Suppressed	Increase in the percentage of clients with a viral load of <200 among PLWH in care in the San Francisco EMA	Viral Load Suppression Among Persons in HIV Medical Care & HIV Viral Load Suppression		▪ Outpatient Medical Care ▪ Pharmaceutical Assistance ▪ Medical Case Management ▪ Medical Transportation ▪ Treatment Adherence
		Baseline: **10,899 / 12,043 - 90.5%**	**FY 2021 Target:** **11,436 / 12,567 – 91.0%**	

Attachment 8: FY 2020 Service Category Plan Tables

Service Category Plan Table # 1: Non-MAI Part A Funding

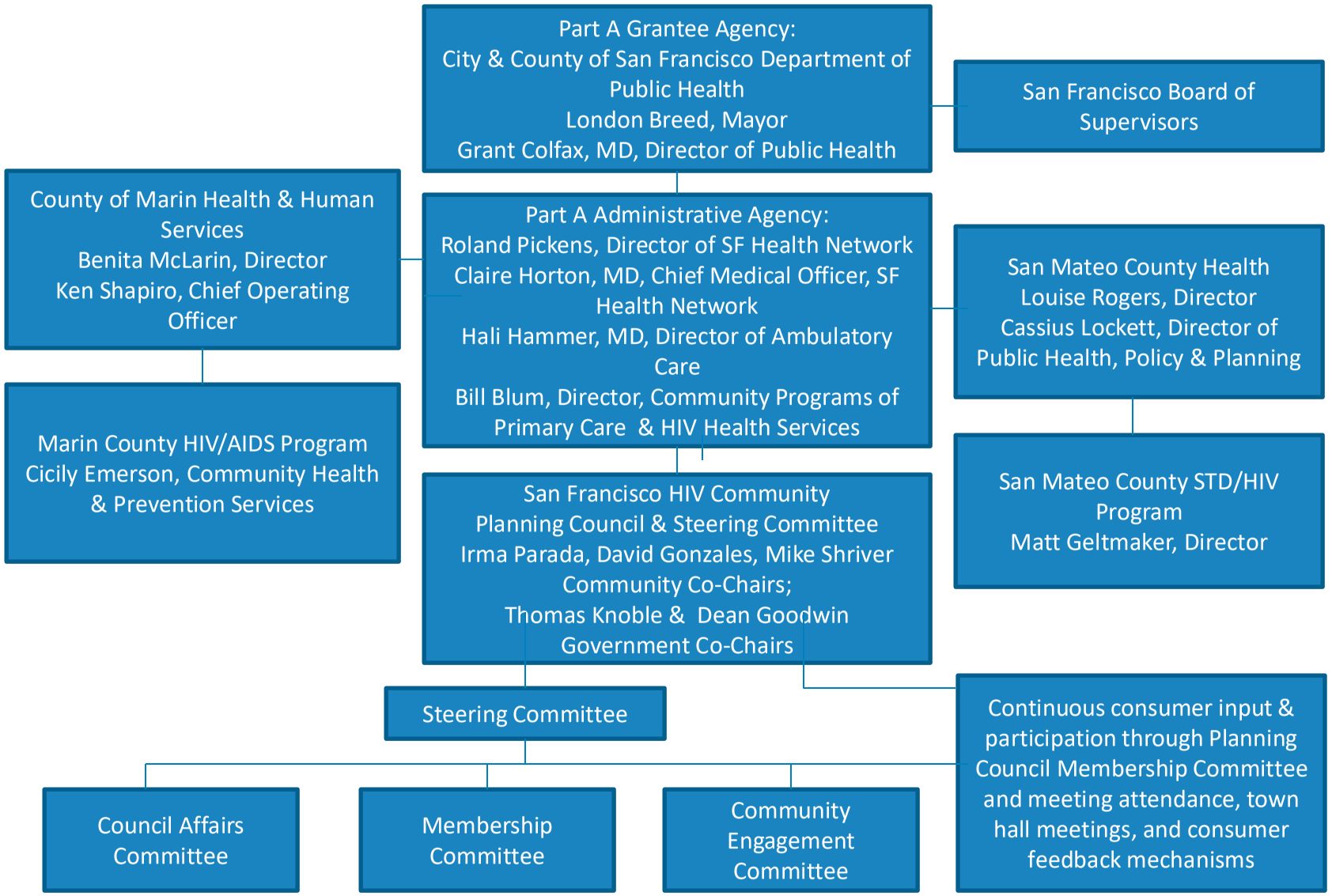
Service Category	Service Unit Definition	FY 2020 As Submitted With Prior Part A Application				FY 2021 Anticipated			
		Priority #	Allocated Funding Amount	UDC Served	Service Units	Priority #	Allocated Funding Amount	UDC Served	Service Units
Core Medical Services									
Outpatient/ Ambulatory Health Services	1 unit = 1 visit	2	$2,435,962	2,758	45,210	2	$549,788	622	10,204
Medical Case Management, including Treatment Adherence	1 unit = 1 hour	4	$1,997,290	521	51,583	4	$3,197,076	834	82,569
Hospice Services	1 unit = beds x days	9	$851,308	46	12,425	9	$851,008	46	12,421
Mental Health Services	1 unit = 1 hour	1	$1,503,439	2,375	21,374	1	$1,570,461	2,481	22,327
Oral Health Care	1 unit = 1 visit	5	$858,131	1,397	7,628	5	$857,829	1,397	7,625
Health Insurance Premium & Cost Sharing Assistance	1 unit = 1 request	N/A	$56,799	67	175	N/A	$50,560	60	156
Early Intervention Services	1 unit = 1 test	10	$119,101	429	3,299	10	$134,500	484	3,726
Substance Abuse Services - Outpatient	1 unit = 1 SA assess-ment or treatment session	6				6	$197,522	364	2,244

Service Category	Service Unit Definition	FY 2020 As Submitted With Prior Part A Application				FY 2021 Anticipated			
		Priority #	Allocated Funding Amount	UDC Served	Service Units	Priority #	Allocated Funding Amount	UDC Served	Service Units
Home Health Care	1 unit = 2 hours attendant care, 1 unit = 2 hours home-maker service	8	$284,645	71	3,177	8	$284,545	71	3,176
Support Services									
Housing Services	Varies	1,2,7	$755,582	171	7,824	1,2,5	$570,290	129	5,905
Emergency Financial Assistance	1 unit = 1 request	3	$1,196,779	1,631	4,051	3	$1,194,964	1,629	4,045
Non-Medical Case Management	1 unit = 1 visit	9	$2,087,393	999	31,661	9	$2,310,097	1,106	35,039
Food Bank / Home-Delivered Meals	1 unit = 1 lb. food, 1 unit = 1 prepared meal, 1 unit = 1 grocery bag	4	$266,252	1,246	1,089,636	4	$247,018	1,156	1,010,921
Other Professional Services (Legal)	1 unit = 1 hour of legal service	8	$305,504	376	4,805	8	$305,396	376	4,803
Outreach Services	1 unit = 1 hour	12	$287,318	601	3,658	13	$287,217	601	3,657
Medical Transportation	1 unit = 1 ride	10	$10,147	106	286	10	$22,753	238	641
Psychosocial Support Services	1 unit = 1 hour	5	$515,757	528	14,545	6	$513,906	526	14,493

Service Category Plan Table # 2: MAI Part A Funding

Service Category	Service Unit Definition	FY 2020 As Submitted With Prior Part A Application				FY 2021 Anticipated			
		Priority #	Allocated Funding Amount	UDC Served	Service Units	Priority #	Allocated Funding Amount	UDC Served	Service Units
Core Medical Services									
Outpatient/ Ambulatory Health Services	1 unit = 1 visit	2	$516,250	101	6,787	2	$541,648	106	7,121
Medical Case Management, including Treatment Adherence	1 unit = 1 hour	4	$207,963	191	5,371	4	$207,890	191	5,369
Substance Abuse Services - Outpatient	1 unit = 1 SA assess-ment or treatment session	6				6	$87,941	162	999

Attachment 10. FY 2021 San Francisco, California Eligible Metropolitan Area Program Organizational Chart



Attachment 11. Maintenance of Effort Documentation

b.1) Maintenance of Effort Table – See table below

SF EMA MAINTENANCE OF EFFORT REPORTING CATEGORIES	Actual FY 2020	Anticipated FY 2021
CORE MEDICAL SERVICES		
AMBULATORY / OUTPATIENT MEDICAL CARE		
▪ **San Francisco County:** Total charges for ambulatory services from local General Funds spent on program expenses over and above costs of direct core medical service and support services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue. (UCSF COE – AA, CCHAMP, Women's)	**$3,429,286**	**$3,329,674**
▪ **San Mateo County Primary Medical Care:** Total charges for ambulatory services from local General Funds spent on program expenses over and above costs of direct core medical service and support services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$346,756**	**$350,000**
MENTAL HEALTH SERVICES		
▪ **San Francisco County:** Total charges for mental health services from local General Funds spent on a program expenses over and above costs of mental health services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue. (SVABHS & UCSF Outpatient)	**$1,405,559**	**$1,450,903**
▪ **San Mateo County:** Total charges for mental health services from local General Funds spent on a program expenses over and above costs of mental health services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$74,265**	**$74,500**
MEDICAL CASE MANAGEMENT SERVICES		
▪ **Marin County:** Total charges for medical case management services from local General Funds spent on a program expenses over and above costs of medical case management services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$119,400**	**$88,350**

SF EMA MAINTENANCE OF EFFORT REPORTING CATEGORIES	Actual FY 2020	Anticipated FY 2021
HOME HEALTH CARE SERVICES		
▪ **San Francisco County**: Total charges for home health care services from local General Funds spent on a program expenses over and above costs of home health care services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue. (Health at Home & Westside)	**$430,107**	**$430,107**
SUPPORT SERVICES		
RESIDENTIAL SUBSTANCE ABUSE SERVICES		
▪ **San Francisco County:** Total charges for residential substance abuse services from local General Funds spent on a program expenses over and above costs of residential substance abuse services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$1,495,098**	**1,495,098**
NON-MEDICAL CASE MANAGEMENT SERVICES		
▪ **San Francisco County:** Total charges for referral for Non-Medical Case Management (Benefits Counseling and Referrals) from local General Funds spent on a program expenses over and above costs of health care and supportive services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue. (SFAF – Benefits Counseling)	**$270,688**	**$274,946**
▪ **San Francisco County:** Total charges for non-medical case management (**benefits counseling**) services from local General Funds spent on a program expenses over and above costs of medical case management services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue. (PRC work order)	**$252,072**	**$252,072**
▪ **San Francisco County:** Total charges for non-medical case management (**employment training and readiness services**) services from local General Funds spent on a program expenses over and above costs of mental health services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue. (PRC)	**$252,000**	**$252,000**
HOUSING SERVICES		

SF EMA MAINTENANCE OF EFFORT REPORTING CATEGORIES	Actual FY 2020	Anticipated FY 2021
▪ **San Francisco County:** Total charges for housing services from local General Funds spent on a program expenses over and above costs of housing services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$7,219,534**	**$7,302,941**
TOTAL MAINTENANCE OF EFFORT	**$15,294,765**	**$15,300,591**

b.2) Description of Process to Determine Reported Expenditures

The San Francisco Office of AIDS Administration utilizes a diverse range of expense fields to track and monitor maintenance of effort expenditures, as described in the table above. This includes expenditures for core and non-core Part A services and expenditures that incorporate all three counties of the San Francisco EMA. Utilizing a cross-service approach provides a reliable indicator of continuing support for HIV/AIDS services throughout the region.

The following attachment is not included in the view since it is not a read-only PDF file.

Upon submission, this file will be transmitted to the Grantor without any data loss.

Attachment 13.pdf

OMB Number: 4040-0010
Expiration Date: 12/31/2022

Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: San Francisco Department of Public Health

DUNS Number: 1037173360000

* Street1: 1380 Howard Street, 4th Floor

Street2:

* City: San Francisco

County: San Franciscov

* State: CA: California

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 94102-2628

* Project/ Performance Site Congressional District: CA-012

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code:

* Project/ Performance Site Congressional District:

Additional Location(s)

Add Attachment | Delete Attachment | View Attachment

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** Project Narrative.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

APPROACHING ZERO IN A TIME OF CRISIS:
SAN FRANCISCO EMA FY 2021 RYAN WHITE PART A
COMPETING CONTINUATION APPLICATION NARRATIVE

INTRODUCTION

The San Francisco Eligible Metropolitan Area (EMA) requests a total **$15,739,566** in Fiscal Year 2021 Ryan White Part A Formula and Supplemental funding to continue to respond to the ongoing local crisis of HIV infection; maintain and enhance the local comprehensive model continuum of HIV care; and develop and implement innovative, effective, and collaborative models for identifying, linking, and retaining persons in HIV care. In alignment with both local and national HIV goals and initiatives, our programmatic mission is to achieve the maximum possible level of viral load suppression across all impacted populations and neighborhoods, with the primary goal of making the San Francisco EMA the first metropolitan region in the United States to **effectively eliminate new infections and halt HIV disease progression**. Requested Part A funding will ensure an integrated, comprehensive, and culturally competent system of care focused on reducing inequities and disparities in HIV care access and outcomes while working toward full health justice and health equity in regard to accessing prevention, medical care, and support services for all residents in the region. The FY 2021 Part A Service Plan described in the present application supports an integrated continuum of intensive health and supportive services for complex, severe need, and multiply diagnosed populations which are structured to support and further self-management through personal empowerment of persons living with HIV (PLWH). The Plan also highlights the San Francisco EMA's continually expanding integration of HIV care services with HIV, hepatitis, and sexually transmitted infection (STI) outreach, testing, linkage, and care retention services, while incorporating the perspectives and input of consumers, providers, and planners from across the region. The FY 2021 Part A application presents an effective strategy to preserve and advance a tradition of HIV service excellence in the San Francisco EMA while serving as a national model for eliminating new HIV infections through regional viral suppression.

NEEDS ASSESSMENT

A. Demonstrated Need

1. Epidemiologic Overview

Overview of the Geographic Region: Located along the western edge of the San Francisco Bay in Northern California, the San Francisco Eligible Metropolitan Area (EMA) is a unique, diverse, and highly complex region. Encompassing three contiguous counties - **Marin County** to the north, **San Francisco County** in the center and **San Mateo County** to the south - the EMA has a total land area of **1,016** square miles, an area roughly the size of Rhode Island. In geographic terms, the EMA is very narrow, stretching more than 75 miles from its northern to southern end, but less than 20 miles at its widest point from east to west. This complicates transportation and service access in the region, especially for those in Marin and San Mateo

Counties. In San Mateo County, the Santa Cruz mountain range marks the western boundary of the San Andreas Fault bisects the region from north to south, creating challenges for those attempting to move between the county's eastern and western sides. The San Francisco (SF) EMA is also unusual because of the dramatic difference in the size of its member counties. While Marin and San Mateo Counties have a land area of **520** and **449** square miles, respectively, San Francisco County has a land area of only **46.7** square miles, making it **by far the smallest county in California** geographically, and the **sixth smallest county in the US** in terms of land area. San Francisco is also one of only three major cities in the US (the others are Denver and Washington, DC) in which the city's borders are identical to those of the county in which it is located. The unification of city and county governments under a single mayor and Board of Supervisors allows for a streamlined service planning and delivery process.

According to the US Census, as of July 1, 2019, the total population of the San Francisco EMA is **1,906,948**.[1] This includes a population of **261,627** in Marin County, **889,360** in San Francisco County, and **776,252** in San Mateo County, with widely varying population densities within the three regions. While the density of Marin County is **485** persons per square mile, the density of San Francisco County is **17,179 persons per square mile** - the highest population density of any county in the nation outside of New York City. While San Mateo County lies between these two extremes, its density of **1,602** persons per square mile is still more than ten times lower than its neighboring county to the north. These differences necessitate varying approaches to providing HIV care within the EMA.

The geographic diversity of the San Francisco EMA mirrors the diversity of the people who call the area home. Nearly three out of every five of the EMA's residents (**59.1%**) are persons of color, including Asian/Pacific Islanders (**29.8%**), Latinxs (**18.9%**), and African Americans (**4.1%**). In San Francisco, persons of color make up **59.8%** of the total population, with Asian residents alone making up over **one-third** (**36.0%**) of the City's total population. The nation's largest population of Chinese Americans lives in the City of San Francisco and is joined by a diverse group of Asian immigrants, including large numbers of Japanese, Vietnamese, Laotian, and Cambodian residents. A large number of Latinx immigrants also reside in the EMA, including natives of Mexico, Guatemala, El Salvador, and Nicaragua. EMA-wide, **31.6%** of residents were born outside the US and **42.1%** of residents speak a language other than English at home, with over **100** separate Asian languages and dialects spoken in SF. Only **half** of the high school students in the City of San Francisco were born in the United States, and almost **one-quarter** have been in the country six years or less. A total of over **20,000** new immigrants join the EMA's population each year, in addition to at least **75,000** permanent and semi-permanent undocumented residents.

a. Summary of the Local HIV Epidemic: Please see **HIV Demographic Table** in **Attachment 3**

b. Socioeconomic Characteristics of Persons Affected by HIV:

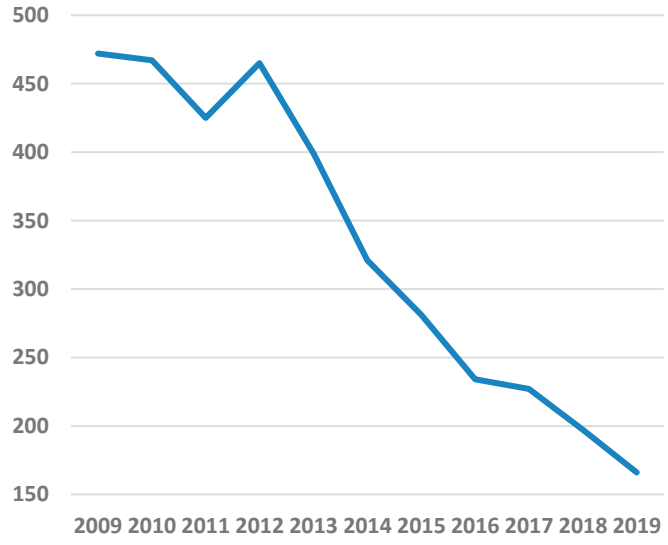
i. Demographic Data: More than 35 years into the HIV epidemic, the three counties of the San Francisco region continue to be severely impacted by HIV – an ongoing crisis that has exacted an enormous human and financial toll on our region. As of December 31, 2019, over

42,000 cumulative cases of HIV had been diagnosed in the region, and over **25,000** persons have died as a result of the local HIV epidemic. As of the end of 2019, a total of **15,054** persons were currently living with HIV in the region's three counties, representing **9.0%** of Californians living with HIV and **1.3%** of all persons living with HIV in the US. [2] The SF EMA's region-wide HIV infection rate of **789.4** cases per 100,000 persons also means that roughly **1 in every 127 residents of the San Francisco region is now living with HIV.** This figure of 15,054 living HIV cases represents the most up-to-date data provided from the State of California, and is based strictly on the number of persons living with HIV who have a **current address** in the San Francisco EMA. Several thousand more living cases of HIV have been diagnosed in the San Francisco EMA, but are not included in our proposal in order to be as accurate as possible regarding the current state of local HIV care needs. Additionally, many persons travel to the City of San Francisco to seek HIV care each month, but are also not included in our estimate of the local HIV care burden.

At the epicenter of the continuing HIV crisis lies the City and County of San Francisco, the city hardest-hit during the initial years of the AIDS epidemic and an area still hugely impacted by HIV**.** Today, the City of San Francisco continues to have the nation's highest per capita prevalence of cumulative AIDS cases,[3] and HIV remains the leading cause of death in the city among all age groups, as it has been for nearly two decades.[4] As of the end of 2019, a total of **12,728** San Franciscans were living with diagnosed HIV infection who had a **confirmed current address** in the city, representing **84.5%** of all persons living with HIV in the three-county region, for a staggering citywide prevalence of **1,447.3 cases of HIV per 100,000.** At the same, the CDC reports a total of **15,908** San Francisco PLWH in San Francisco as of the end of 2019, including persons who may have moved out of the city, which results in a per capita HIV incidence of **1,788.7 per 100,000.**

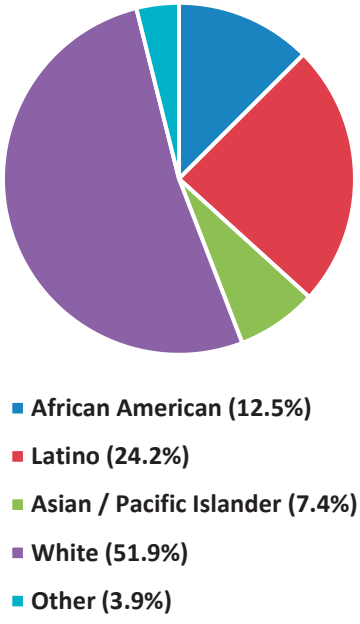
In 2018, the City of San Francisco recently achieved an important milestone: for the first time since the start of the epidemic, fewer than 200 new HIV cases were diagnosed in the city (n=**197**). **This milestone has been surpassed in 2019 with the identification of only 166 new cases of HIV in the city.** This represents a decrease of **26.9%** from the **227** new HIV cases diagnosed in 2017 and a startling **64.8% reduction** from the **472** new HIV cases diagnosed in the city in 2009, only a decade before. The record-breaking decline in new HIV diagnoses speaks to the city's integrated, systemwide strategy resulting from its plan to become the first city in the nation to achieve a goal of zero new HIV infections.

Figure 1. New Annual HIV Infections in the City of San Francisco - 2009 -2018



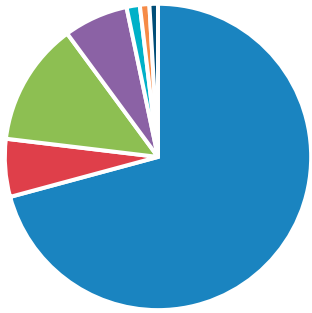
Race / Ethnicity: Reflecting the ethnic diversity of our region, the local HIV caseload is distributed among a

Figure 2. Persons Living with HIV in the San Francisco EMA by Ethnicity as of December 31, 2019



wide range of ethnic groups. Because the local HIV epidemic had its first broad impact on white men who have sex with men (MSM), the slight majority of persons living with HIV continue to be white (**51.9%**). Another **12.5%** of cases are among African Americans; **24.2%** are among Latinx individuals; and **7.4%** are among Asian / Pacific Islanders (see **Figure 2**). A total of **7,244** persons of color were living with HIV infection in the three-county region as of December 31, 2019, representing **48.1%** of all persons living with HIV. African Americans are significantly over-represented in terms of HIV infection, making up **12.5%** of all persons living with HIV while comprising only **4.1%** of the area's population. This disproportion is even greater among **women** with HIV, a group in which African American women make up **37.2%** of all PLWH while comprising **4.0%** of the region's total female population. Additionally, among the region's hard-hit transgender population, persons of color make up **82.1%** of all trans PLWH, including a population that is **31.4%** African American, **35.8%** Latina, and **10.2%** Asian / Pacific Islander.

Figure 3. Persons Living with HIV in San Francisco EMA by Transmission Category as of December 31, 2019

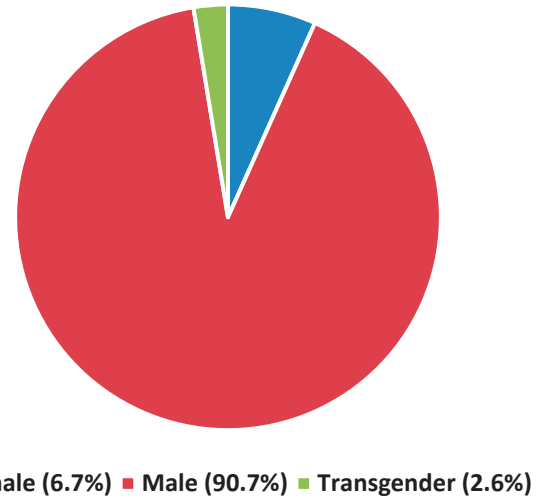


Transmission Categories*:* The most important distinguishing characteristic of the HIV epidemic in the San Francisco region is that HIV remains primarily a disease of men who have sex with men (MSM). In other regions of the US, the proportionate impact of HIV on MSM has declined over time as populations such as women, injection drug users, and heterosexual men have been increasingly affected by the epidemic. While these groups have been impacted in our region as well, their representation as a proportion of total PLWH has remained relatively low. Through December 31, 2019, fully **82.7%** of persons living with

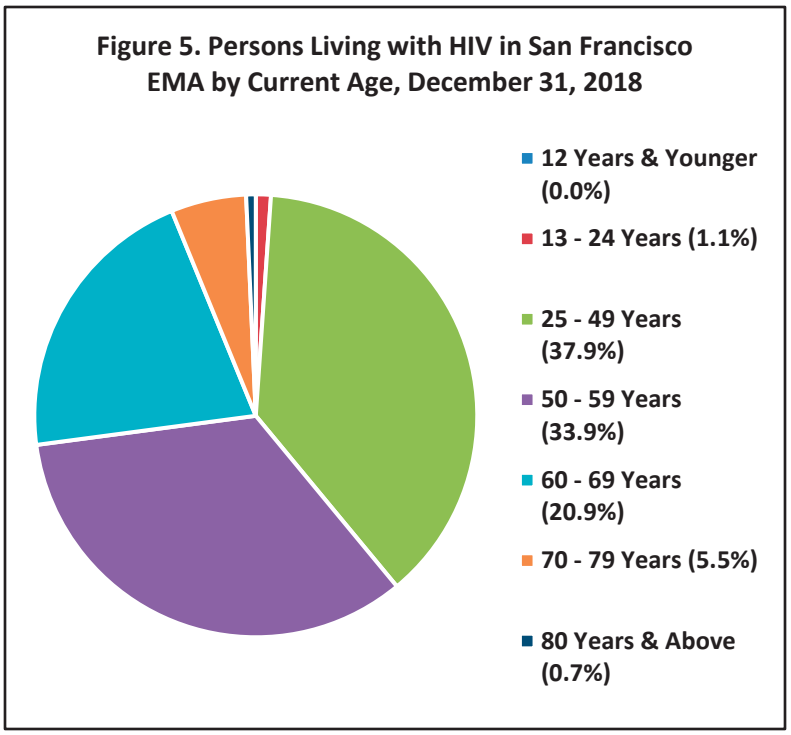
HIV in our region were MSM (**12,451**), including **10,657** men infected with HIV through MSM contact only (**70.8%** of all PLWH) and **1,794** MSM who also injected drugs (**11.9%** of all PLWH) (see **Figure 3**). This actually represents a slight increase from a decade ago, in 2008, when MSM made up **82.3%** of all PLWH. By comparison, only **44.5%** of all PLWH in New York City as of June 30, 2019 were listed as infected through MSM contact – roughly **half** the MSM infection burden of the San Francisco EMA.[5] Factors underlying this difference include the high proportion of gay and bisexual men living in the region; the large number of local long-term MSM HIV survivors; growing rates of STD infection among MSM, resulting in large part from expanding PrEP use; and relatively high local drug use rates, including an ongoing methamphetamine use crisis. Other significant local transmission categories include heterosexual persons who inject drugs (PWID) (**6.3%** of PLWH) and non-PIWD heterosexuals (**6.8%**). **The proportion of heterosexual HIV cases in the San Francisco EMA is believed to be the lowest of any EMA in the US.** Additionally, **1.4%** of all PLWH in the San Francisco EMA are transgender women who have sex with men (WSM) while another **1.0%** are transgender WSM who inject drugs.

Gender: Reflecting the high prevalence of HIV among men who have sex with men, the vast majority of persons living with HIV in the San Francisco region (**90.7%**) are cis men (see **Figure 4**). Only **6.7%** of PLWH in the region are cis women, over **71%** of whom are women of color. Among African Americans living with HIV, **15.2%** are women. **The three-county San Francisco region has historically contained what is by far the lowest percentage of women, infants, children, and youth (WICY) living with HIV of any HIV region or jurisdiction in the nation.** Because of their high representation within the San Francisco population, **transgender persons** also make up a significant percentage of PLWH, with at least **387** transgender individuals - the vast majority of them male-to-female – living with HIV as of December 31, 2019, representing **2.6%** of the region's PLWH caseload. It is believed that many transgender persons move to San Francisco seeking a more tolerant environment, increased social support, and greater access to culturally responsive trans health and social services.

Figure 4. Persons Living with HIV in San Francisco EMA by Gender as of December 31, 2019



Current Age: The vast and growing majority of persons living with HIV in the San Francisco region are age 50 and above. This is attributable to the long history of the epidemic in our region - resulting in a large proportion of long-term survivors - and to the region's hard-fought success in bringing persons with HIV into care and maintaining their health over time. As of December 31, 2019, **more than 3 out of every 5** persons living with HIV in the SF EMA (**62.8%**) is age 50 or older, including **5,065** PLWH between the ages of 50 and 59; **3,133** PLWH between the ages of 60 and 69; **822** PLWH between the ages of 70 and 79; and **100** PLWH who



are age 80 or older (see **Figure 5**). In the city of San Francisco, persons 50 and older make up **68.8%** of all persons living with HIV. Between December 2009 and December 2019, the number of persons 50 and over living with HIV increased by **44.8%** within the region while the number of PLWH 65 and older increased by **91.2% over the last 36 months alone**. **Figure 6** on the following page provides a demographic overview of the 50 and older HIV population as of the end of 2019 - a population that includes **601** women, **180** transgender persons, and over **1,000** men and women with HIV age 70 or higher, including **117** PLWH age 80 or above. This growing aging population creates significant challenges for the local HIV service system, including the need to coordinate and integrate HIV and geriatric care and to plan for long-term impacts of HIV drug therapies.

In terms of other age groups, persons between the ages of 25 and 49 make up **37.0%** of all PLWH in the region (n=**5,571**) while young adults ages 13 - 24 make up only **1.0%** of all PLWH in the region (n=**135**). However, young people ages 13 - 24 made up **10.0%** of all new HIV cases identified in calendar year 2019 alone (n=**27**), pointing to a continued growing HIV incidence within this population, although the actual number of new infections continues to decrease. The population of young PLWH also includes a significantly higher percentage of **persons of color**, who make up **82.5%** of young people with HIV ages 13 - 24 while making up **48.1%** of the overall PLWH population. The same is true for **cis women**, who make up **16.1%** of youth PLWH as compared to only **6.7%** of all PLWH in the EMA. Only **3** children age 12 or under are living with HIV in the region, and **no** new HIV cases have been diagnosed among this group since 2005.

ii) Socioeconomic Data:

Poverty: The problem of poverty presents a daunting challenge to the HIV care system. According to the US Census, the average percentage of persons living at or below federal poverty level stands at **12.6%** for the entire San Francisco region. Using this data, SF DPH projects that at least **720,826** individuals in the San Francisco region are living at or below 300% of Federal Poverty Level for a family of three (**$65,160**). This translates to at least **37.8%** of the EMA's population lacking resources to cover all but the most basic expenses. **However, at the time of this writing, this percentage is believed to be much higher and growing rapidly as a**

result of the severe economic impacts of the COVID-19 pandemic. Additionally, because of the high cost of living in the San Francisco Bay Area, persons at 300% of poverty or below have a much more difficult time surviving in our area than those living at these income levels in other parts of the U.S. Analyzing 2018–2019 data from the San Francisco AIDS Regional Information and Evaluation System (ARIES), the SF region's client-level data system, it is estimated that at least **60.7%** of all persons living with HIV in the San Francisco region (n=**9,081**) are living at or below 300% of the 2019 Federal Poverty Level (FPL) including persons in impoverished households, while **98.8%** of Part A-funded clients live at or below 400% of poverty.[6] ARIES data also reveals that **76.0%** of active Ryan White Part A clients in the San Francisco region are currently living at or below 138% of FPL while another **14.9%** are living between 139% and 250% of FPL. HIV-infected persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **$318 million** in Part A and non-Part A HIV-related expenditures in the San Francisco region each year[7].

Figure 6. San Francisco EMA FY 2021 Part A Application 50 and Older HIV Epidemiology Table

Persons 50 and Older		Persons Living with HIV as of 12/31/19	
Race/Ethnicity	African American	1,189	12.7%
	Latino / Hispanic	1,709	18.3%
	Asian / Pacific Islander	498	5.3%
	White (not Hispanic)	5,636	60.4%
	Other / Multiethnic / Unknown	305	3.3%
Gender	Female	601	6.4%
	Male	8,556	91.6%
	Transgender / Other Gender Identification	180	1.9%
Age as of 12/31/19	50 - 59 Years	4,987	53.4%
	60 - 69 Years	3,294	35.3%
	70 - 79 Years	939	10.1%
	80 Years and Above	117	1.3%
Transmission Category			
	Male-to-male sexual contact (MSM)	6,615	70.8%
	Injection drug use (IDU)	679	7.3%
	MSM and IDU	1,177	12.6%
	Heterosexual contact	575	6.2%
	TWSM	79	0.8%
	TWSM-PWID	92	1.0%
	Unknown risk	94	1.0%
	Other	26	0.3%
TOTAL		**9,337**	**100%**

The problem of poverty is greatly amplified by the **growing disparity between rich and poor in San Francisco** which has become a critical issue over the past decade as a continuing influx of young professionals from the Silicon Valley to the south has prompted rapid gentrification and the upheaval of many formerly low and middle-income neighborhoods. According to the Brookings Institution, the San Francisco metropolitan area has the **3rd highest level** of household income inequality of any region in the US in (after Bridgeport, CT and New York, NY) while the City of San Francisco itself has the **5th highest level** of income inequality of all cities in the US.[8] The Public Policy Institute of California reports that San Francisco Bay Area has the widest level of income disparity of any region in the state, with residents in the 90th

percentile of incomes earned **$384,000** per year as compared to **$32,000** for those in the bottom 10th percentile, meaning that the richest Bay Area residents earned more than **10 times** that of its poorest residents. [9]

Housing and Homelessness: **Housing** is an indispensable factor in ensuring good health outcomes for persons with HIV. Without adequate, stable housing it is highly challenging for individuals to access primary care; maintain combination therapy; and preserve overall health and wellness. These issues are more critical for persons with co-morbidities such as substance addiction and/or mental illness, since maintaining sobriety and medication adherence is much more difficult without stable housing. Homelessness is also a critical risk factor for HIV, with one study reporting HIV risk factors among **69%** of homeless persons.[10]

Figure 7.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs, 2020

County	Hourly Wage to Rent a 2-Bdrm. Apt. at HUD Fair Market Rents
San Francisco County, CA	$ 64.21
Marin County, CA	$ 64.21
San Mateo County, CA	$ 64.21
Santa Clara County, CA	$ 57.12
Santa Cruz County, CA	$ 48.44
Santa Barbara County, CA	$ 44.69
Alameda County, CA	$ 43.06
Contra Costa County, CA	$ 43.06
Orange County, CA	$ 42.62
Honolulu County, HI	$ 41.54

Because of the prohibitively high cost of housing in the San Francisco region and the shortage of affordable rental units, the problem of homelessness has reached crisis proportions, creating formidable challenges for organizations seeking to serve HIV-infected populations. According to the National Low Income Housing Coalition's *Out of Reach 2020* report, Marin, San Francisco, and San Mateo Counties – the three counties that make up the San Francisco region – **are tied with one another as the three least affordable counties in the nation** in terms of the minimum hourly wage needed to rent an average two-bedroom apartment, which currently stands at **$64.21 per hour** (see **Figure 7**).[11] This means that an individual must make more than $64 an hour to afford a 2-bedroom apartment, and represents an increase of **nearly 40% in the last 36 months alone**. Meanwhile, according to the 2021 HUD Fair Market Rent Documentation System, San Francisco has the **highest HUD-established Fair Market Rental rate in the nation** at **$2,350** for a studio apartment and **$3,553** for a 2-bedroom apartment, which represents the amount needed to "pay the gross rent of privately owned, decent, and safe rental housing of a modest nature".[12]

At the same time, despite aggressive efforts that had shown progress, San Francisco saw a **16.8% jump** in the number of homeless residents over the past two years, from **6,858** homeless persons in 2017 to **8,011** homeless persons in 2019, according to the most recent Point in Time Homeless Count, even as youth and veteran homelessness decreased by **10.1%** and **14.3%**, respectively.[13] This trend is reflective of other homelessness increases in major cities across the nation. Additionally, more than **59%** of single parents in SF also live below the **California Self-Sufficiency Standard (SSS)**, a measure that incorporates the cost of basic needs for California's working families.[14] An analysis of 2018-2019 ARIES data revealed that **less than two-thirds** of

Ryan White Part A clients were stably housed during the year (**66.3%**), with **23.8%** living in temporary housing and **5.8%** living in unstable housing, including in shelters and on the street.

Insurance Coverage:

The advent of health care reform through the Affordable Care Act (ACA) has resulted in significant, positive change in regard to the number and proportion of low-income persons with HIV in our region who benefit from affordable and more accessible health insurance coverage. According to the Public Policy Institute of California, approximately **93.0%** of Californians now have some form of health insurance, up from **82.5%** in 2013.[15] However, this still means that about **2.8 million** Californians lacked health insurance in 2017, with approximately **two-thirds** (**65%**) of those insured being Latinx persons.[16] Nevertheless, significant insurance gaps remain in our region. Analysis of local ARIES data revealed that **29.4%** of all persons enrolled in Ryan White Part A services in the three-county region during the 2018-2019 fiscal year were uninsured at some point during the year, including persons without Medicaid or Medicare.

Additionally, significant **disparities** exist in regard to type of health insurance coverage among newly diagnosed persons with HIV. For example, while the percentage of persons in San Francisco who had insurance at the time of HIV diagnosis in 2019 was relatively comparable across ethnic groups (**71%** of whites: **75%** of African Americans; **62%** of Latinxs; and **59%** of Asian / Pacific Islanders), fully **26%** of newly diagnosed Latinx and API still had no form of insurance. Additionally, the **type** of insurance varied greatly among populations. For example, while **39%** of whites had private insurance at the time of HIV diagnosis, only **22%** of African Americans and **27%** of Latinxs had private insurance. Conversely, while **23%** of whites and **27%** of Latinx persons had Medicaid coverage at the time of diagnosis, fully **40%** of African Americans were covered by Medicaid at the time of initial HIV diagnosis.

The issue of persons **losing their private disability insurance** is growing in importance as the population of PLWH 50 years and older increases and as these individuals are more likely to rely on private disability insurance than their younger counterparts. In October of 2014, the San Francisco Board of Supervisors, Budget and Legislative Analyst Office released a Policy Analysis Report on PLWH who age off Long Term Disability Insurance. The report reviewed data from several sources to estimate the number of PLWH who have private disability insurance and will reach retirement age and Social Security eligibility in the next 15 years. The report found that over **1,200** PLWH over 50 years old rely on private disability insurance, which terminates at age

65. The overall effect of the drop in income that will occur as people lose their private disability insurance is difficult to predict conclusively. However, evidence does suggest that for many PLWH, the lost income would make it impossible to afford San Francisco's current median rent.

Burden of HIV in the Service Area: It is important to note that the City of San Francisco continues to have the **largest per capita concentration of persons living with HIV of any metropolitan region in the United States.** As noted above, as of the end of 2019, a total of **12,728** San Franciscans were living with diagnosed HIV, representing **84.5%** of all persons living with HIV in the EMA. **This means that 1 in every 70 San Francisco residents is now living with HIV disease - an astonishing concentration of HIV infection in a city with just under 890,000 residents.** The incidence of **1,447.3** persons living with HIV per 100,000 in San Francisco County is **more than three times** that of Los Angeles County in Southern California (**459.8** per 100,000).[17]

c. New HIV Infections:

i. Trends in New HIV Infections: As a result of the SF EMA's integrated and comprehensive collaborative efforts to expand HIV awareness and testing and link and retain persons with HIV in care, new HIV infections in our region continue to decline across all age groups, while the disparities gap for new infections among African Americans and Latinx populations is also beginning to close. The total of **272** new cases of HIV infection diagnosed in the SF EMA in calendar year 2019 is the fewest number of regional new infections in the history of the HIV epidemic, while the **166** new HIV cases diagnosed in the city of San Francisco represents a **42.8% reduction** over the past 5 years (from **290** new cases in 2015), and a **64.7% reduction** over the past decade (from **470** new cases in 2010). Between 2010 and 2019, the number of newly identified HIV infections among whites in San Francisco declined by **74.1%**, from **224** to **58** new cases, while the number of newly identified cases among African Americans declined by **56.3%,** from **64** in 2010 to **28** in 2019. The number of new HIV diagnoses among Latinx individuals in SF also dropped from **109** in 2019 to **54** in 2019, a reduction of **50.1%**. Per capita rates of new HIV diagnoses among SF women also dropped over the past decade, with rates of new HIV diagnoses among African American women dropping from **39** infections per 100,000 in 2010 to **22** infections per 100,000 in 2019. Similarly, rates of new HIV infection for Latinx women declined from **12** per 100,000 to **7** per 100,000, while rates among white women dropped from **8** per 100,000 to only **2** per 100,000.

At the same time, it is critical to note that **communities of color** continue to have by far the highest incidence of new HIV infections in the San Francisco EMA, and that rates of new infections among these groups continue to outpace their representation in the overall PLWH population. Rates of new HIV infection in SF in 2019 stood at **79** per 100,000 among African American men and **61** per 100,000 among Latinx men, as compared to rates of only **26** per 100,000 among white men and **12** per 100,000 among Asian / Pacific Islander men. And while **24.2%** of all PLWH in the EMA as of the end of 2019 were Latinx, fully **40.1%%** of all new EMA HIV diagnoses in 2019 occurred within this population. At the same time, while Asian / Pacific Islanders made up **7.4%** of all PLWH at the end of 2019, they accounted for **14.3%** of all new 2019 HIV diagnoses. Similar increases are also occurring among **women**, who made up **6.8%** of PLWH at the end of 2019 but made up **8.8%** of all new HIV diagnoses in 2019 Even more

dramatic are HIV cases among **transgender persons**, who accounted for **2.6%** of all PLWH at the end of 2019 but fully **5.9%** of all new HIV cases identified in 2019. Additionally, young people between the ages of 13 and 24 make up only **1.0%** of PLWH in the EMA, but made up **10.0%** of all new HIV diagnoses in 2019.

The San Francisco EMA's overall success in reducing the number of new HIV infections stems from a variety of factors, including ongoing Ryan White funding; San Francisco's longstanding model of comprehensive and integrated HIV outreach, testing, linkage, and care services; our region's strong commitment to supporting comprehensive HIV services; California's early embrace of the Affordable Care Act (ACA); and the efforts of the SF **Getting to Zero Consortium**, (www.gettingtozerosf) a multi-sector initiative involving community-based organizations, providers, researchers, health department and government officials, consumers, and activists, which has been working since 2014 toward the goals of zero new HIV infections, zero HIV-associated deaths, and zero HIV stigma and discrimination. The local Getting to Zero Consortium has resulted in San Francisco serving in some ways a **national laboratory** for testing whether focused HIV initiative across the care continuum can eventually reduce and eliminate HIV as a public health threat. Additional successes of these efforts include the following:

- Overall, **94%** of people living with HIV in San Francisco are estimated to be **aware of their infection.**
- In 2019, **95%** of new HIV diagnoses in San Francisco were linked to care within **one month** of diagnosis.
- In 2018, **81%** of newly diagnosed persons with HIV achieved viral suppression **within one month** of diagnosis and fully **78%** of persons newly diagnosed with HIV achieved viral suppression **within six months** of diagnosis.
- In 2018, only **5.5%** of new HIV diagnoses were among **persons who inject drugs (PWID)** due to the success of extensive syringe access programs in San Francisco.

ii. <u>Increasing Need for HIV Services:</u> While the successes of the San Francisco approach to HIV prevention, identification, and care are both significant and heartening, it is critical to note that a large share of the model's success is attributable to the **significant federal resources** for both prevention and care, including efforts to more rapidly identify and link persons with HIV to care and to retain them in care and on medication regimens on a long-term basis. This includes expanded Medicaid reimbursement through ACA and the continuing support for HIV care through Ryan White Part A and other programs, which enable persons with HIV to achieve long-term viral suppression and reduce the rate of new HIV infections in our region. At the same time, the total number of persons living with HIV in the EMA continues to grow, and the increasing number of persons 50 and older with HIV puts additional demands on the system to meet more complex HIV-related aging needs of long-term survivors. To sustain the success of the San Francisco approach to eliminating HIV, and to allow the region to continue to serve as a national laboratory for HIV case reductions, these federal resources will continue to be of the utmost importance. Any reduction in federal support for health, HIV, and related services has the potential to rapidly undo the progress we have made and back to coping with a public health emergency in which funds are inadequate to stop a new surge of HIV infection and HIV-related morbidity and mortality.

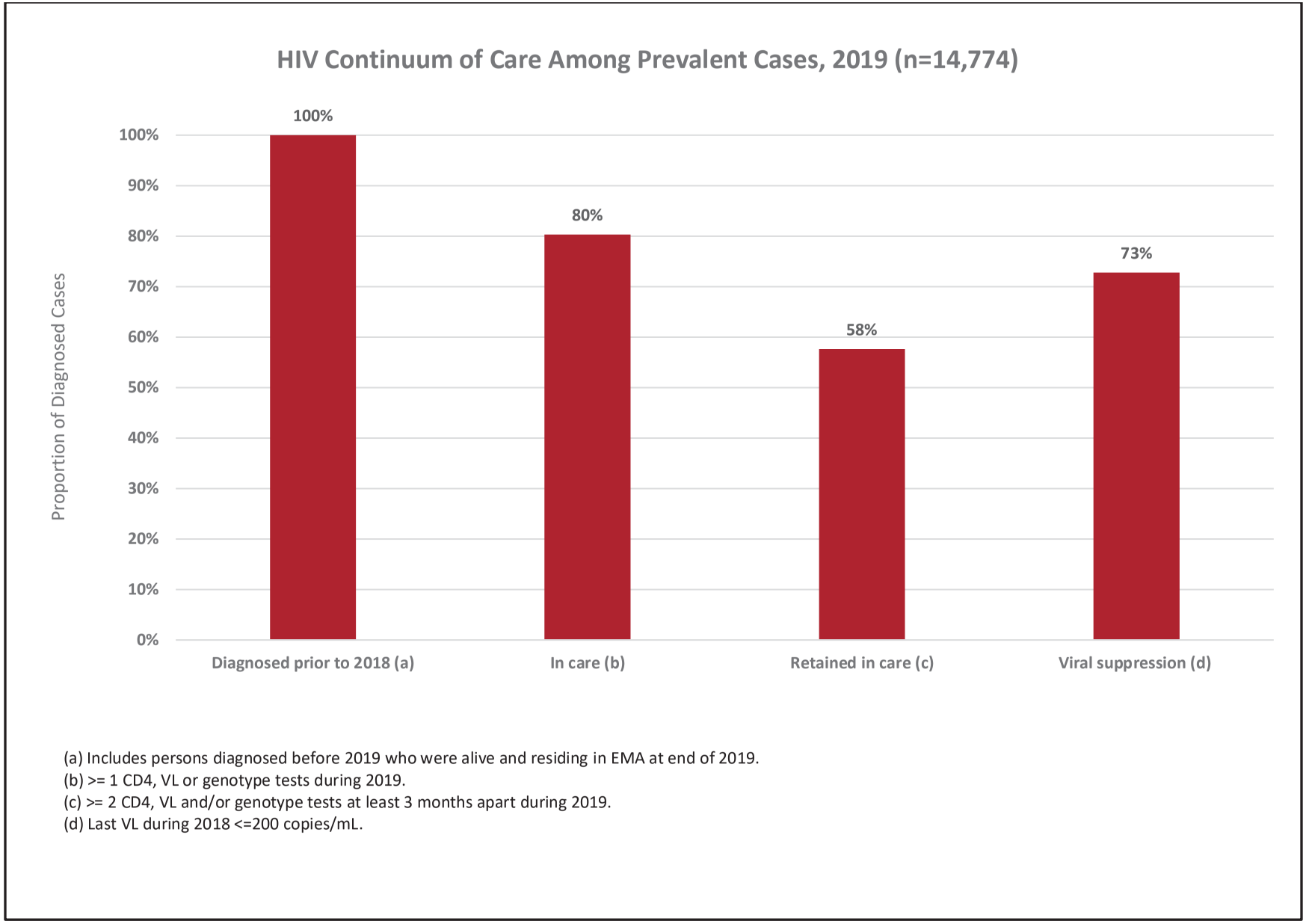
2. HIV Care Continuum

The chart on the following pages depicts the HIV care continuum for the San Francisco EMA for calendar year 2019. As noted on the table, the EMA has achieved remarkable success in linking and retaining persons in care and in achieving viral suppression across the region. A total of **80%** of all persons with a confirmed HIV diagnosis currently living in the EMA are engaged in care, defined as at least 1 CD4, viral load, or HIV genotype test during calendar year 2018, while fully **73%** of have achieved viral load suppression at the time of the most recent viral load test – defined as less than 200 copies per ml. - an increase of **1%** over the previous year. Additionally, **58%** of SF EMA PLWH were retained in care in 2018, based on a definition of at least 2 reportable HIV-related lab tests at least 3 months apart in a calendar year – a standard of care that is becoming increasingly less stringently adhered to for individuals who have been durably virologically suppressed and on stable ARV regimens and who are requesting annual intervals between medical visits. The significantly higher percentage of persons with durable viral suppression compared to the number of persons with 2 or more medical visits in a year may speak to the success of this overall approach, although more information is needed to verify this.

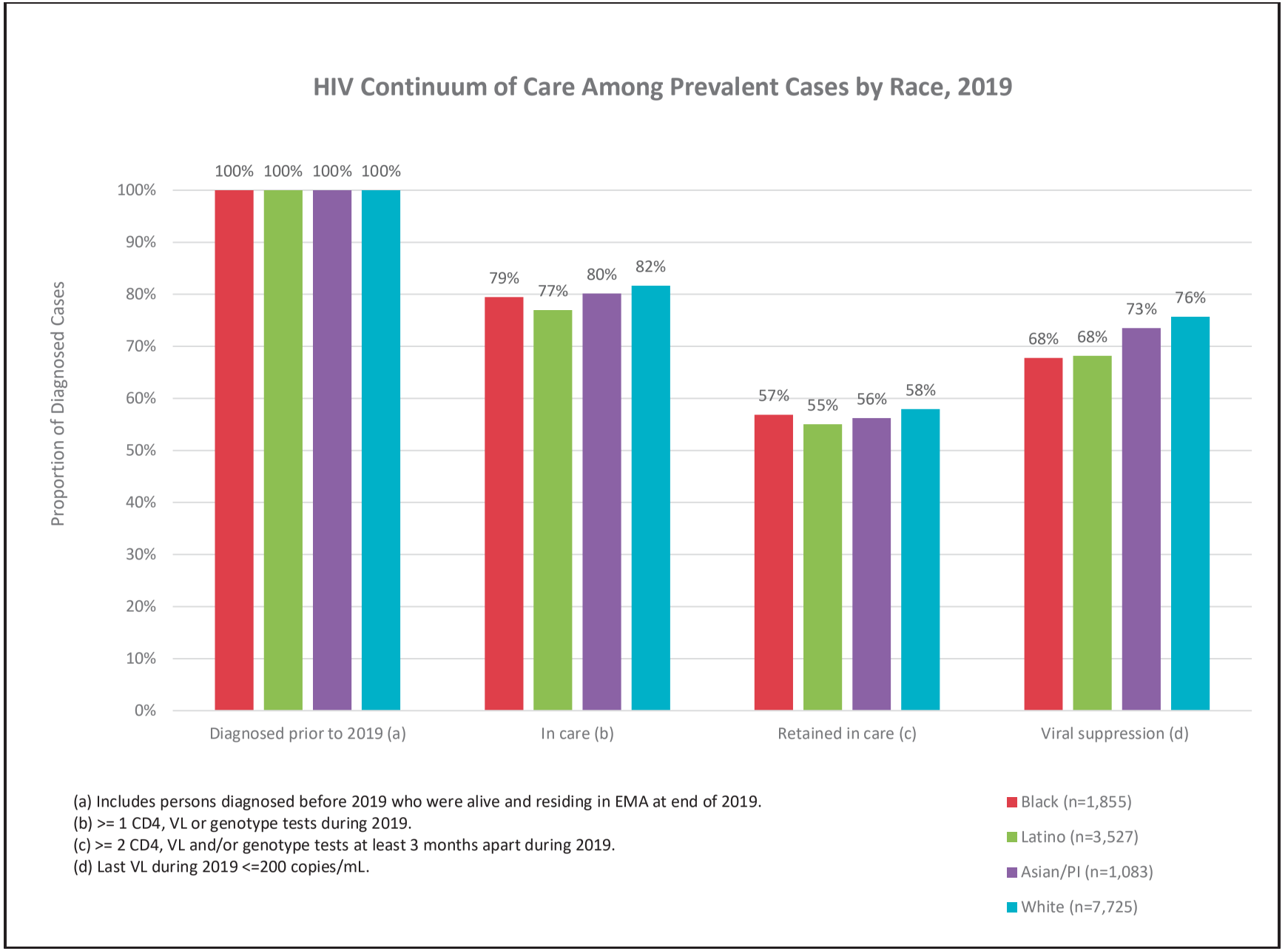
Despite the region's success in achieving a high level of care engagement and viral load suppression, significant disparities in HIV continuum outcomes continue to exist, particularly in regard to **ethnicity**. As noted in the comparison chart that follows the overall HIV continuum table, for example, while **82%** of white PLWH are retained in care (defined as at least 1 HIV-related lab test per year) only **77%** of Latinx populations are retained in care. And while **76%** of white PLWH achieved viral suppression in 2019, only **68%** of African Americans and Latinx populations had achieved viral suppression. These and other disparities are aggressively addressed both in our proposed FY 2021 EIIHA Plan and in our proposed FY 2021 Part A care retention strategies, which include population-specific initiatives to better ensure long-term retention and medication adherence, including the significant expansion of support for **medical case management** to provide focused retention support to populations facing complex life challenges.

3. Co-Occurring Conditions

Please see **Co-Occurring Conditions Table** in **Attachment 4.**



(a) Includes persons diagnosed before 2019 who were alive and residing in EMA at end of 2019.
(b) >= 1 CD4, VL or genotype tests during 2019.
(c) >= 2 CD4, VL and/or genotype tests at least 3 months apart during 2019.
(d) Last VL during 2018 <=200 copies/mL.


HIV Continuum of Care Among Prevalent Cases by Race, 2019
Proportion of Diagnosed Cases
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100% 100% 100% 100%
79% 77% 80% 82%
57% 55% 56% 58%
68% 68% 73% 76%
Diagnosed prior to 2019 (a)
In care (b)
Retained in care (c)
Viral suppression (d)
(a) Includes persons diagnosed before 2019 who were alive and residing in EMA at end of 2019.
(b) >= 1 CD4, VL or genotype tests during 2019.
(c) >= 2 CD4, VL and/or genotype tests at least 3 months apart during 2019.
(d) Last VL during 2019 <=200 copies/mL.
Black (n=1,855)
Latino (n=3,527)
Asian/PI (n=1,083)
White (n=7,725)

Sexually Transmitted Infections (STIs): The San Francisco EMA as a whole - and the city of San Francisco in particular - are in the midst of a growing and unprecedented epidemic of sexually transmitted infections. While this epidemic reflects a larger, ongoing epidemic affecting the entire State of California, it is having particularly acute consequences for our region, and speaks to our need to redouble our efforts to continue to reach and test persons at high risk for HIV. In terms of **syphilis**, for example, the SF Jurisdiction continues to confront a major epidemic that has been escalating for the past two decades, rising more than **550%** since 2000. In calendar year 2018 – the last date for which data is available - a total of **635** new primary and secondary syphilis cases were diagnosed in the three-county San Francisco region, representing a **177%** increase over the **229** cases reported in 2007.[18] The combined SF jurisdiction-wide syphilis rate of **32.1** per 100,000 in 2018 is significantly higher than the California statewide rate of **19.1** per 100,000. Within the City of San Francisco alone, a total of **544** new syphilis cases were reported in 2017 for an extremely high citywide incidence rate of **61.3** cases per 100,000, a rate **more than three times higher** than the statewide rate and **more seven times higher** than the national syphilis rate of **8.7** cases per 100,000 in 2017 (see **Figure 8**). **San Francisco County has by far the largest syphilis infection rate of any of California's 59 counties, 41.8% higher** than the rate of the second highest county, San Joaquin County (**35.7** per 100,000) and nearly **three times** that of Los Angeles County (**23.0** per 100,000).

Figure 8. New Primary & Secondary Syphilis Cases Per 100,000 Population - Selected Metropolitan Areas

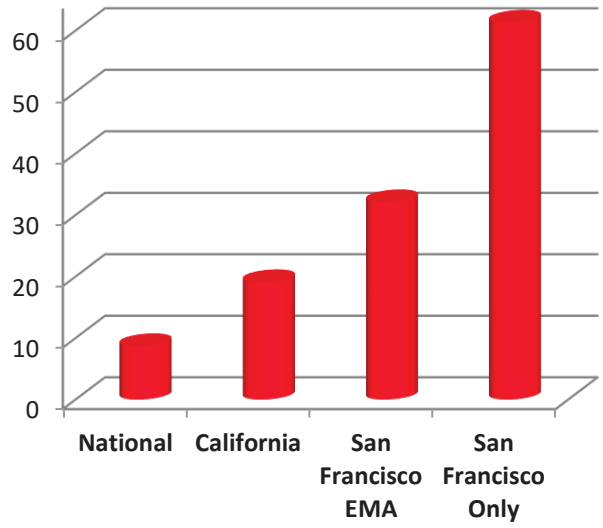
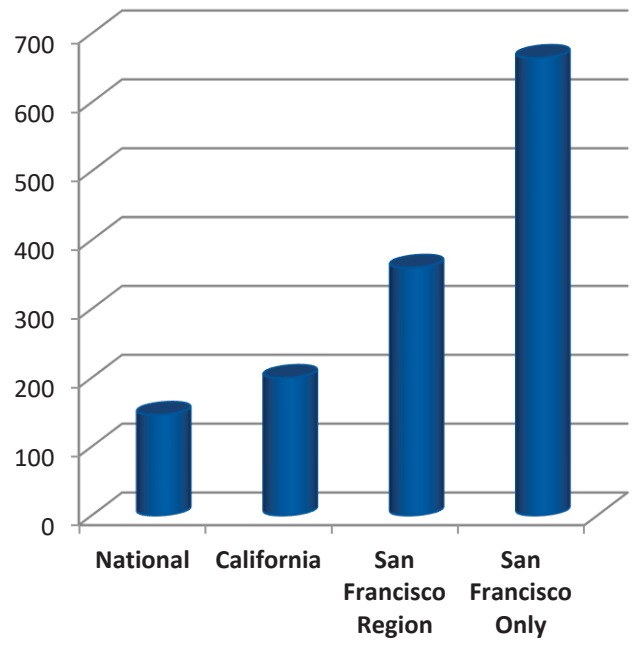
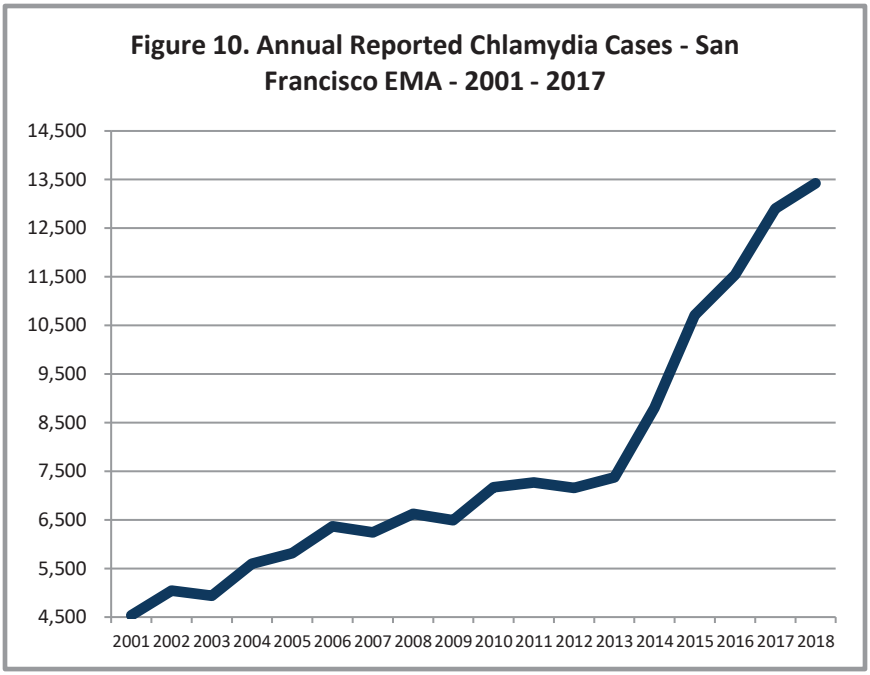


Figure 9. New Gonorrhea Cases Per 100,000 Population - Selected Metropolitan Areas



The region is also experiencing a significant **gonorrhea** epidemic. A total of **6,823** new gonorrhea cases were identified in the San Francisco EMA in 2018, for a Jurisdiction-wide incidence of

359.4 cases per 100,000 – a rate **44.5% higher** than the 2018 California rate of **199.4** cases per 100,000 (see **Figure 9**).[19] The number of new gonorrhea cases in the city of San Francisco increased by **200%** between 2010 and 2018 alone, growing from **1,927** reported cases in 2010 to **5,894** cases in 2017. The City of San Francisco's 2018 gonorrhea incidence of **656.4** cases per 100,000 is **more than four times** the national rate of **145.8** cases per 100,000 and **more than three times higher** than the State of California as a whole (**199.4**). **This is again also by far the highest rate of any county in California,** with the next highest county – Lake County – having a case rate of **262.4** per 100,000, **significantly less than half** the gonorrhea rate of San Francisco.



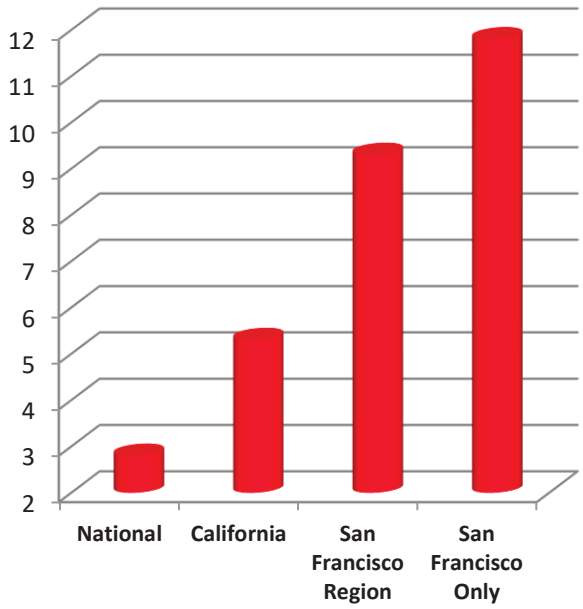
The region's **Chlamydia** epidemic also continues to increase, with rates rising significantly. A total of **13,423** new cases of Chlamydia were diagnosed in the three-county region Jurisdiction in 2018, representing a **131%** increase over the **5,816** cases diagnosed in 2005 (see **Figure 10**).[20] The 2018 Jurisdiction-wide Chlamydia incidence stood at **680.5** per 100,000, while the rate for the City of San Francisco was **1,070.9** cases per 100,000 - **again, by far the highest Chlamydia incidence rate of any county in California**. By comparison, the 2018 incidence for California was **538.0** cases per 100,000, while the national rate was **497.3.**

The cost of treating STIs adds significantly to the cost of HIV care in the San Francisco Jurisdiction. According to a study which estimated the direct medical cost of STIs among American youth, the total annual cost of the 9 million new STI cases occurring among 15-24-year-olds totaled $6.5 billion in the US, at a per capita cost of $7,220 per person. Lissovoy and colleagues estimated US national medical expenditures for congenital syphilis for the first year following diagnosis at between $6.2 million and $47 million for 4,400 cases, or as high as $10,682 per case.[23] A study published in the American Journal of Public Health estimated that a total of 545 new cases of HIV infection among African Americans could be attributed to the facilitative effects of infectious syphilis, at a cost of about $113 million, or a per capita cost of $20,730.[24] Such studies suggest that the total cost of treating new STIs in our region may be as high as **$13.9 million** per year, including an estimated **$1.95 million** to treat STIs among persons with HIV and another **$7.5 million** in potential annual costs resulting from the need to treat persons infected with HIV as a result of transmission facilitated through other STIs.

Tuberculosis (TB): Tuberculosis is an additional critical health factor linked to HIV, particularly among recent immigrants and the homeless. The magnitude of the local TB crisis is comparable to syphilis and gonorrhea, with a combined total of **179** new cases of TB diagnosed

in the three-county region in 2019, representing an area-wide incidence of **9.3** cases per 100,000. In San Francisco, the incidence is even higher, at **11.8** cases per 100,000, although this is a decrease from the rate of **13.2** per 100,000 in 2018. San Francisco County's 2019 TB rate ranked **second** out of California's 58 counties, while San Mateo County ranked **fifth**. San Francisco's TB incidence rate is **more than double** the statewide rate of **5.3** cases per 100,000 and **nearly four times higher** than the national rate of **2.8** cases per 100,000 (see **Figure 11**).[27] Treatment for multi-drug resistant tuberculosis is particularly expensive, with one study indicating that the cost averaged $89,594 per person for those who survived, and as much as $717,555 for patients who died.

Figure 11. New Tuberculosis Cases Per 100,000 Population, 2019 - Selected Metropolitan Areas



Hepatitis C: The hepatitis C virus (HCV) is the nation's most common blood-borne infection, a major cause of liver cancer, and the leading cause of liver transplants in the US. In the United States as a whole, HCV prevalence is approximately **five times greater** than HIV prevalence, and approximately **25%** of HIV-positive individuals are co-infected with HCV infection.[21] Community-based antibody screening among high–risk populations in San Francisco has yielded a HCV antibody positivity rate of **5.4%,** while HCV antibody screening in San Francisco jails has yielded an antibody positivity rate of **10%.** Surveillance data also indicates tremendous disparities in HCV prevalence in San Francisco. While African Americans represent **6.6%** of San Francisco's general population, they account for at least **one-third** of San Francisco's HCV cases and **23.5**% of the population of people who are co-infected with HIV and HCV. The San Francisco Department of Public Health also estimates that as many as **90%** of all chronic injection drug users over the age of 30 have hepatitis C. Despite the tremendous disease burden of HCV, there has historically been a dearth of federal, state, and local funding for HCV surveillance, prevention, and care activities.

At the same time, however, significant advances have been made in hepatitis C treatment over the past several years with new treatments that have **successful cure rates of over 90%** in persons living with HCV. While these treatments are extremely costly, the San Francisco region has taken the initiative to comprehensively treat all HCV-infected individuals in an attempt to **end hepatitis C among persons living with HIV by the end of 2019 -** a direct objective contained in this document's Action Plan. The **End Hep C SF** initiative is built on three distinct pillars: 1) Citywide community-based HCV testing for highly impacted populations paired with augmented HCV surveillance infrastructure to track the HCV epidemic and progress towards elimination; 2) Linkage to care and treatment access for all people living with HCV; and 3) Prevention of new HCV infections and reinfection in those cured of HCV. The initiative will be

specifically applied to persons living with HIV in concert with the San Francisco Department of Public Health and local HIV clinics and care sites. The City is excited by the prospect of heading a model program to dramatically extend HIV lifespan and health by striving to eliminate Hep C among persons with HIV over the next three years.

Additional Co-Factors: The high prevalence of **mental illness** and **mental health issues** in the San Francisco EMA complicates the task of delivering effective services and retaining persons with HIV in care. The San Francisco Department of Public Health Behavioral Health Section's most recent report noted that **12,000** seriously emotionally disturbed children and youth and **32,000** seriously mentally ill adults live in San Francisco, and that up to **37%** of San Francisco's homeless population suffers from some form of mental illness.[22] In part because of the Golden Gate Bridge, San Francisco also has one of the nation's highest rates of both adult and teen suicide completion, and the rate of suicide per capita in San Francisco is **twice as high** as the city's homicide rate.[23] When coupled with the second highest incidence of homelessness in the US, these statistics reflect the high incidence of multiply diagnosed clients in the EMA. Among persons with severe mental illness, the research literature documents a broad range of HIV seroprevalence rates, from **4%** to as high as **23%.**[24] Mental illness, depression, and dementia are also increasingly common among HIV-diagnosed populations, with **31%** of HIV clients at one San Francisco clinic having concomitant mental illness, and **80%** of clients at another clinic having a major psychiatric condition. One recent study found a **37%** prevalence of depression in HIV-infected men in San Francisco.[25]

Substance use also plays a central role in the dynamics of the HIV epidemic, creating challenges for providers while and a critical barrier to care for HIV-infected individuals. The EMA is in the throes of a major substance abuse epidemic which is fueling the spread not only of HIV but of co-morbidities such as sexually transmitted infections, hepatitis C, mental illness, and homelessness **–** conditions that challenge the care system's ability to bring in and retain PLWH in care. According to the most recent report by the California Office of Statewide Health Planning and Development, an average of **8.5** hospitalizations per 10,000 occurred in San Francisco, well above the average statewide rate of **6.6** per 10,000.[26] At the same time, the rate for drug-induced deaths in San Francisco stood at **24.8** per 100,000, more than double the statewide rate of **10.8** per 100,000.[27] Drugs and drug-related poisonings are also the **leading** cause of injury deaths among San Franciscans, **with an average of three San Franciscans dying each week of a drug-related overdose or poisoning**.[28] In terms of HIV, the most alarming current threat involves the local epidemic of **methamphetamine** (**speed).** Health experts currently estimate that up to **40%** of gay men in San Francisco have tried methamphetamine,[29] and recreational crystal use has been linked to **30%** of San Francisco's new HIV infections in recent years.[30]

4. Complexities of Providing Care

a. Reduction in Part A Formula Funding:

i. Impact: For the sixth consecutive year, the San Francisco EMA experienced a reduction in Part A formula funding, with formula funds decreasing by $109,996 from FY 2019-20 to FY 2020-21, a reduction of **1.2%** in the formula award. Coupled with a reduction in Part A

supplemental funding of **$282,834**, the SF EMA experienced a combined reduction of **$367,940** in Part A funding between the previous and current Ryan White fiscal years. The Planning Council utilized pre-established contingency plans which applied this reduction to proportional cuts in Part A support services.

ii. Response: While no severe service reductions took place in the SF EMA as a result of Part A funding reductions, these annual reductions continue to place tremendous strain on the local system of HIV care, necessitating the shifting of greater financial burdens onto the medical and social service community. Local medical providers are forced to subsidize greater and greater shares of unreimbursed indigent care costs, while the number of clients who are able to access many key services must be carefully monitored. **The economic impacts of the COVID-19 epidemic have also begun to have serious repercussions for low-income persons with HIV in the SF EMA by eliminating discretionary funding that in past years might have been used to help backfill some lost Part A funding.** While our region's success in reducing the rate of new HIV infections is able to alleviate some of the pressures from funding reductions, the economic effects of the COVID-19 crisis are only beginning to be felt, and are expected to have devastating impacts lasting well into and through the next Ryan White fiscal year.

b. Poverty and Health Care Coverage Table: (See **Figure 12** below)

Figure 12. Poverty and Health Care Coverage Table

Demographic Category	Unduplicated Clients Enrolled in Ryan White Services in SF EMA 3/1/18 - 2/28/19	
Federal Poverty Level (FPL)		
0 - 138% of FPL	5,427	76.0%
139% - 250% of FPL	1,062	14.9%
251 - 400% of FPL	251	4.8%
401% of FPL and Higher	88	1.2%
Current Living Situation		
Stable	4,736	66.3%
Temporary	1,702	23.8%
Unstable	411	5.8%
Insurance Status		
Private	686	9.6%
Medicare	2,165	30.3%
Medicaid	4,508	63.1%
No Insurance	2,100	29.4%
Other	3,479	48.7%

- Basic Threshold for Ryan White Eligibility in SF EMA: **400% or Less** of Current FPL
- Note: Chart excludes individuals for whom poverty or insurance status is unknown
- Insurance Status percentages add up to more than 100% due to multiple insurance streams

c. Factors Limiting Access to Health Care / Service Gaps

Factors Limiting Health Care Access: Despite regional successes in reducing the number of persons who are not covered by insurance, some barriers to ongoing, universal health care coverage continue to exist. Many homeless and highly impoverished persons with HIV entering care are either not currently covered by insurance or have had their coverage lapse in the recent past, a factor that accounts for the relatively large percentages of clients in the table above who have been listed as having "no insurance" at some point during the previous Ryan White fiscal year. The vast majority of these individuals are rapidly enrolled in Medicaid or other insurance programs upon presenting for care at HIV service sites. The same issue applies to incarcerated persons, who frequently lose their coverage while in prison or jail, and who must be re-enrolled and re-qualified following their release. In some cases, individuals who are enrolled in the **San Francisco Health Plan** are listed as having no insurance because the Plan is not technically a health insurance plan. For the most part, however, SF EMA HIV providers have become highly adept at both enrolling and re-certifying persons with HIV in appropriate insurance and benefits plans, and ensure that the vast majority of persons living with HIV in our region have access to high-quality care and support services on an ongoing basis.

In terms of **service gaps,** the chart below compares the population of PLWH enrolled in the San Francisco EMA Ryan White system of care for FY 2018-2019 with the EMA's combined PLWH population as of 12/31/18 (see **Figure 13**). Because of the high cost of living in our region, the qualifying threshold for RWHAP eligibility in the SF EMA is **400%** of Federal Poverty Level (FPL).

Figure 13. Comparison of San Francisco EMA Ryan White Clients with Overall PLWH Population

(**NOTE:** Due to staff reassignments at the SF Department of Health due to the COVID-19 epidemic, a comprehensive analysis of Ryan White clients for the 2019-2020 fiscal year was not feasible. The chart below reflects the composition of Ryan White clients for the previous fiscal year, compared to 2018 HIV populations.)

Demographic Group / Exposure Category	Total Unduplicated Clients Enrolled in Ryan White Services - 3/1/18 - 2/28/19*		Combined SF EMA PLWH Population as of 12/31/18		Population Variances - Ryan White vs. All PLWH
Race/Ethnicity					
African American	1,357	18.9%	1,859	12.4%	**+ 6.5%**
Latinx / Hispanic	1,919	26.9%	3,529	23.6%	**+ 3.3%**
Asian / Pacific Islander	460	6.4%	1,098	7.3%	**- 0.9%**
White (not Hispanic)	2,887	40.4%	7,897	52.8%	**- 12.4%**
Other / Multiethnic	306	4.2%	577	3.9%	**+ 1.3%**
Gender					
Female	787	11.0%	1,002	6.7%	**+ 5.1%**

Demographic Group / Exposure Category	Total Unduplicated Clients Enrolled in Ryan White Services - 3/1/18 - 2/28/19*		Combined SF EMA PLWH Population as of 12/31/18		Population Variances - Ryan White vs. All PLWH
Male	6,080	84.6%	13,563	90.7%	**- 6.1%**
Transgender	273	3.8%	395	2.6%	**+ 1.0%**
Age					
0 - 24 Years	99	1.6%	163	1.1%	**+ 0.5%**
25 - 44 Years	2,005	27.5%	3,893	26.0%	**+ 1.5%**
45 - 64 Years	4,083	57.2%	8.737	58.4%	**- 1.2%**
65 Years and Above	836	13.3%	2,167	14.5%	**- 1.2%**
Transmission Categories					
MSM	4,008	56.1%	10,818	72.3%	**- 16.2%**
Injection Drug Users	779	10.9%	945	6.3%	**+ 4.6%**
MSM Who Inject Drugs	629	8.8%	1,938	13.0%	**- 4.2%**
Non-IDU Heterosexuals	807	11.3%	1,018	6.8%	**+ 4.5%**
Other	100	1.4%	56	0.4%	**+ 1.0%**
Unreported / Unknown	822	11.5%	185	1.2%	**+ 10.3%**
TOTAL	**7,144**	**100%**	**14,960**	**100%**	

* Note that Ryan White service population figures exclude unknown data

Attesting to our region's success in bringing the most highly impoverished and challenged persons with HIV into Ryan White care, **persons of color, cis women, trans women, younger adults, injection drug users,** and **heterosexuals** are all **over-represented** in the local Ryan White system. Meanwhile **whites, men, MSM**, and **older adults** are **underrepresented** in the system due largely to higher average incomes and higher rates of private insurance, including Medicare in the case of older adults, which reduce their need to rely on Ryan White-funded care. For example, while women make up only **6.7%** of all PLWH in the EMA, they comprise **11.0%** of all Ryan White clients as of February 28, 2019. Meanwhile, while whites make up **52.8%** of all PLWH in the EMA, they comprise only **40.4%** of Ryan White Part A clients as of the same date. Ryan White clinics provide primary medical care to a population that is disproportionately comprised of persons of color, cis and trans women, persons with low incomes, the homeless, heterosexuals, current and former injection drug users, and formerly incarcerated individuals. Additionally, local Part D programs primarily serve young people and women, while Part C programs such as those operated by the San Francisco Clinic Consortium serve the full spectrum of clients, including the homeless, persons of color, women, and gay/bisexual men. Fully **18.9%** of Ryan White clients in the local Ryan White system are African American (n=**1,357**) despite the fact that they comprise **12.4%** of all persons with HIV in the EMA. In fact, fully **83.0%** of all American Americans living with HIV in the EMA are currently receiving care through the Ryan White system, while the total number of African Americans in the Ryan White system increased by **32.8%** over the 2 years alone, from **1,022** African Americans in the system for FY 2016-2017 to **1,357** for FY 2018-2019. Similarly, Latinx populations make up **23.6%** of PLWH in the EMA but comprise **26.9%** of Ryan White clients.

Trans women make up **3.8%** of persons served through the Ryan White system while making up **2.6%** of all persons living with HIV in the EMA. **All of these statistics highlight the progress the San Francisco EMA has made in linking and retaining in care the most impoverished and highly underserved HIV-infected residents of the region.** In fact, between FY 2014 and FY 2018, the number of clients in the local Ryan White system increased by **9.4%**, from **6,503** total clients served in FY 2014 to **7,114** total clients served in FY 2018.

In addition to direct needs assessment activities, a primary methodology for identifying service gaps in our region involves **analyzing disparities** in relation to HIV prevention and care activities. Identified disparities across ethnic, gender, age, and transmission categories reveal the ways in which our system, despite continual progress, is still falling short of equitably meeting the needs of all persons at risk for and living with HIV in our region. Identified disparities also indicate where our region needs to focus its energy and resources to meet our Getting to Zero goals. In terms of disparities along the HIV Care Continuum, the chart below indicates populations that achieve **lower percentages of success** in terms of HIV prevalence, rates of new infection, ART initiation, and viral suppression (see **Figure 14**). For purposes of the table, a "disparity" is defined as occurring when a population is disproportionately affected by an issue, either when compared between specific sub-populations (such as African Americans compared to whites) or when compared to the total population. These disparities are addressed by specific objectives and action steps contained in our action plan, particularly in regard to Objectives #1.2 and 2.2.

Figure 14. Populations Affected by Disparities in Relation to the HIV Care Continuum

Indicator	Populations with Disparities
HIV Prevalence Relative to Size of Sub-Populations	▪ Men Who Have Sex with Men (MSM) ▪ Transfemales ▪ African American MSM ▪ African American Transfemales ▪ Persons 50 years and older ▪ African American Cis Females
Estimated Rate of New Infections per 100,000	▪ MSM ▪ Latinxs ▪ Age Group 13-29
Less Likely to Achieve Antiretroviral therapy (ART) Initiation Compared to Overall Estimated Regional ART Levels	▪ Females ▪ African American ▪ Native American ▪ Multi-racial ▪ Heterosexual ▪ Homeless ▪ Public or No insurance at diagnosis

Indicator	Populations with Disparities
Less Likely to Achieve Viral Suppression Compared to Overall Estimated Regional Viral Suppression Rates	▪ Female ▪ Transfemale ▪ African Americans ▪ Latinx ▪ Current Age Under 40 ▪ People Who Inject Drugs (PWID) MSM-PWID

To address service gaps, the San Francisco HIV Community Planning Council and the SF Department of Public Health work together to ensure that Ryan White Part A funds are coordinated across all applicable funding streams in the region and that they address identified service gaps at all levels of client care. The Planning Council reviews annual service category summaries that include a detailed listing of all Ryan White and non-Ryan White funding sources for each category, including sources such as ADAP, Medicaid and Medicare support, public entitlement programs, private insurance and HMO support, Veterans Administration programs, City and County funds, HOPWA and SAMHSA grants, and State mental health funds. The Grantee also ensures that services are coordinated to maximize accessibility of services, while seeking every possible alternate source of funding apart from Part A to support HIV care.

The San Francisco EMA is also dedicated to ensuring the integration and coordination of **all** sources of Ryan White funding in the region. The Planning Council prioritizes the use of Ryan White funds for services that are not adequately funded through other reimbursement streams to ensure that Part A funds are the funding source of last resort. During each year's priority setting and allocation process, the Grantee produces detailed fact sheets on each service category that include a listing of **all** other funding streams available for that category, including Parts B, C, D, and F programs, ADAP, and MAI funding. The Planning Council also assists in the planning for Part B-funded services. The Planning Council works with other local planning groups including the Long-Term Care Coordinating Council, the Methamphetamine Task Force, and the HIV Housing Work Group to coordinate services and eliminate duplication.

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

"I love the San Francisco model. If it keeps doing what it is doing, I have a strong feeling that they will be successful at ending the epidemic as we know it. Not every last case - we'll never get there - but the overall epidemic. And then there's no excuse for everyone not doing it."

- Dr. Anthony S. Fauci,
Director, National Institute of Allergy and Infectious Diseases
***New York Times*, October 5, 2015[31]**

1. <u>Planned FY 2021 EIIHA Activities</u>

a. <u>Primary Activities To Be Undertaken:</u>

The FY 2021 EIIHA Plan will encompass **three** broad, high-impact prevention (HIP) activity areas that mirror those of preceding EIIHA plans and that build on the significant progress the SF EMA has made through its **Getting to Zero (GTZ)** initiative. The **first** area involves **identifying individuals who are unaware of their HIV status.** The EMA will continue to maintain: a) high-volume, community-based **targeted HIV testing** for MSM, persons who inject drugs (PWID), and transgender women, particularly persons who experiencing homelessness within these populations, incorporating the latest testing technologies as appropriate, including high-quality rapid testing and acute RNA pooled screening and rapid 4th generation combination antibody / antigen (Ab/Ag) tests at sites that do not have access to pooled RNA testing; b) integrated HIV/STI/Hep C testing wherever feasible and appropriate, incorporating chlamydia, gonorrhea, syphilis, hepatitis B and C, and tuberculosis testing; c) routine testing of partners of HIV-positive individuals; d) routine opt-out screening in clinical settings; e) routine perinatal screening; and f) accessible, high quality laboratory-based HIV testing and case reporting. At the same time, over the next three years, the SF EMA will cast a wider net to: a) address disparities in new infections among African Americans and Latinos and b) find cases in low incidence populations such as women. These efforts will include: a) implementing culturally specific community engagement and mobilization with communities of color; b) further normalizing and de-stigmatizing HIV and STD testing to reach beyond those who traditionally test by continuing to expand medically based HIV opt-out testing with 3rd party reimbursement; c) exploring opportunities to expand integrated approaches to sexual health services in novel settings such as HIV/STD screening and PrEP delivery at pharmacies; and d) focusing on mobile services and tele-health in response to the COVID-19 pandemic.

The **second** key activity area involves **ensuring that HIV-positive individuals are successfully linked to essential medical and social services based on individual need**. Specific activities to be undertaken through the Plan will continue to be tailored to meet the needs of its three identified target population groups, with a particular emphasis on continuing to implement the city-wide **Linkage Integration Navigation Comprehensive Services (LINCS) program** for both newly identified and re-linked individuals who have been out of care. Created in 2015, LINCS is a highly effective program designed to increase the number of HIV-infected individuals who are effectively linked to and anchored in care. The LINCS Team provides a comprehensive range of services based on individual client needs and circumstances,

incorporating linkage to HIV medical care, social services, partner services, and retention services under a single umbrella. LINCS employs an integrated team of **15** full-time staff. **Eight** staff provide HIV and syphilis partner services and linkage to care to newly diagnosed patients, and **7** staff provide HIV care navigation to patients who are identified as out of care by healthcare providers or through HIV surveillance data. LINCS Team members are directly paired with newly identified HIV-positive individuals and remain paired in a supportive relationship for up to **three months** following initial HIV diagnosis. This ensures that: 1) linkage to care is made **within 30 days** for **everyone** testing positive in San Francisco; and 2) **all** newly-diagnosed individuals are offered comprehensive and immediate linkage and partner services.

The **third** key activity aims to **promote and facilitate ever-widening utilization of pre-exposure prophylaxis (PrEP) throughout the EMA**, and in particular, to address **disparities in PrEP uptake** in relation to under-utilizing populations such as African Americans, Latinx populations, and transgender women. DPH is leveraging multiple funding sources to implement a multi-pronged approach that includes: 1) community, clinic, and pharmacy-based PrEP programs; 2) training of HIV test counselors to provide a gateway to PrEP; 3) social marketing; 4) mobile PrEP; and 4) public health detailing. San Francisco has vigorously embraced PrEP as an effective approach to reducing new infections among high-risk individuals in the EMA. San Francisco has become known as the premier hub of PrEP use worldwide, with San Francisco chosen as one of two US sites for the global iPrEx study of once-daily Truvada use for gay men, and with the city establishing the nation's first PrEP demonstration project, which has since evolved into an ongoing program.[32] Key elements of San Francisco's PrEP strategy include the following:

- Reducing the interval from when a person wants to begin PrEP to receiving his or her first PrEP dose by increasing access to same-day PrEP;
- Facilitating connections between PrEP programs to ensure no one is on a waiting list;
- Utilizing California's PrEP Drug Assistance Program (PrEP DAP) when it becomes available;
- Increasing collaboration with the school district, its CDC Division of Adolescent and School Health (DASH)-funded program, and local colleges and universities to open additional access points for young MSM and trans female students;
- Incorporating PEP into all PrEP discussions, so that clients who choose not to start PrEP know how to access PEP;
- Closely monitoring PrEP access for young MSM, trans women, and PWID, who have particular challenges related to insurance and stability, and make adjustments in our strategies as needed;
- Continuing to learn from communities about their unique barriers and support and work with community members to develop and disseminate culturally appropriate messaging to address misinformation and remove roadblocks to PrEP access;
- Strengthening panel management systems for PrEP programs at City Clinic, the SFHN and CBOs to identify patients on PrEP who are lost to follow-up or have discontinued PrEP due to changes in insurance status, so there is no interruption in PrEP;
- Scaling up a pharmacist-delivered PrEP program at a community based pharmacy in the Mission district serving Latino clients;
- Ensuring that PrEP services and materials are available in Spanish;

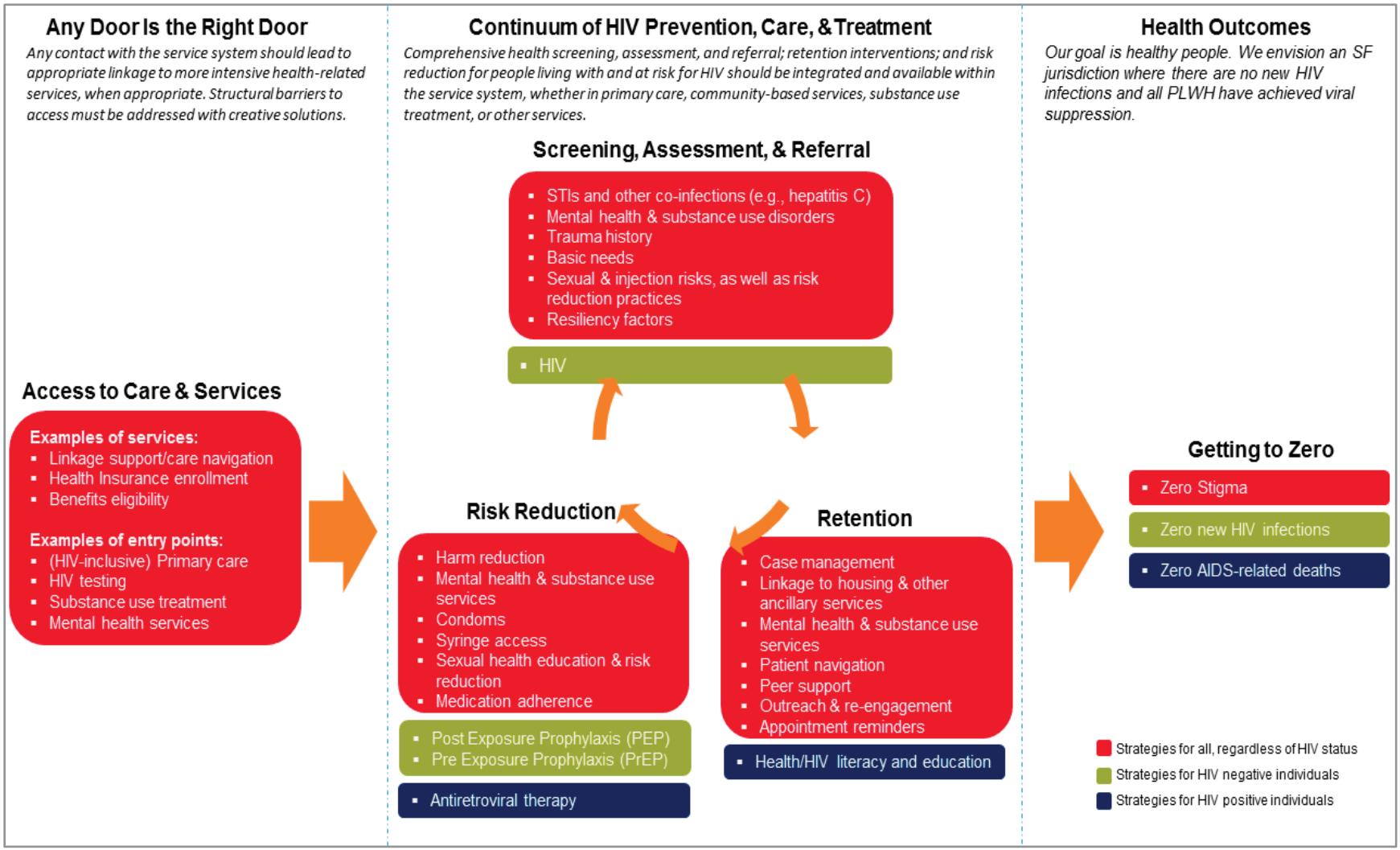
- Integrating PrEP education for PLWH into Ryan White services and other services for PLWH, including PrEP referrals for their partners;
- Expanding access through incentivized, mobile PrEP and through the PrEP program at SF City Clinic, our municipal STD Clinic; and
- Expanding harm reduction services at housing sites.

The SF EMA aims to achieve an HIV prevention and care continuum in which no one is at risk for HIV, and everyone who is living with HIV knows their status, is linked to and retained in care, and is virally suppressed (see **Figure 15**). The EIIHA Plan contributes to improving health outcomes in the following ways:

- Reducing at risk and HIV-infected populations by improving awareness and uptake of PrEP, with a particular focus on African American and Latino MSM, young MSM, and trans women;
- Increasing awareness of HIV status through increasing access to routine HIV testing and community-based rapid testing to detect acute infections. SFDPH continues to promote frequent testing (every 3 to 6 months for the three high prevalence populations - MSM, PWID, and transwomen) and test counselors are trained to deliver this messaging during testing encounters. It is worth noting that the city of San Francisco has the highest rates of HIV status awareness in the nation with only 6.5% not aware of their infection, and with a sero-unaware rate of only 3% among MSM;
- Improving HIV care linkage and retention rates through continued implementation of the LINCS program as well as expanded case management services;
- Increasing viral suppression as a direct result of improvements along the rest of the continuum; and
- Continuing to conduct Data to Care (DTC) activities as a joint initiative between HIV surveillance and the LINCS program, with a special focus on African American and Latino MSM and trans women.

Additionally, the San Francisco Department of Public Health (SFDPH) conducts a **medical chart review** of **every** person living with HIV in San Francisco **every 12 months** to document and update variables not collected at time of initial diagnosis, including vital status, use of additional therapeutic and prophylactic treatments, subsequent opportunistic illnesses, most recent address, and additional CD4 and viral load results. This process also allows us to track and maintain a **current address for all PLWH**, which is a key component to the success of the DTC and LINCS programs. Address information is **geocoded to the census tract level,** enabling HIV surveillance to produce maps shared in our annual epidemiology report and to our prevention partners that show, for example, the geographic distribution of all PLWH, newly diagnosed cases and their viral suppression and linkage to care rates, as well as testing rates by age and zip code.

Figure 15: San Francisco Jurisdiction Holistic Health Framework for HIV Prevention and Care



b. Major Collaborations:

HIV Health Services, which is housed in the ambulatory section of the San Francisco Health Division, works in close partnership with the three Branches in the Population Health Division - Community Health Equity & Promotion (CHEP)**,** Disease Prevention & Control (DPC), and Applied Research, Community Health Epidemiology & Surveillance (ARCHES) Branches to plan services, design interventions, and share data and
emerging findings. CHEP oversees community-based prevention and testing services; DPC oversees the LINCS program and operates City Clinic (the municipal STD clinic which offers HIV testing, PrEP, and HIV early care); and ARCHES maintains the SF spectrum of engagement data as well as facilitating data to care and data to PrEP strategies. In addition, the DPH Primary Care Division is a close partner, providing routine HIV testing, care to people living with HIV, and PrEP access and navigation services.

Through a strong working relationship, these three partner entities are able to closely coordinate prevention and care planning and interventions with the goal of maximizing available resources and ensuring a seamless testing system in the EMA. The collaboration also ensures non-duplication and non-supplantation of Ryan White Program funding. The collaboration is augmented by strong working relationships involving virtually all providers of HIV-specific prevention and care services in the EMA, as well as agencies serving high-prevalence populations at risk for HIV infection.

The EIIHA Plan is supported by two additional key collaborators – 1) the **HIV Community Planning Council (HCPC),** our region's merged HIV prevention and care community planning group, which includes HIV prevention and care service providers from all three counties as well as prevention and care consumers, and 2) the **Getting to Zero (GTZ) Consortium**, a multi-sector independent consortium of public and private sector agencies, service providers, consumers, and planners operating under the principles **of collective impact**. Modeled after the UNAIDS goals, the consortium aims to achieve zero new infections, zero HIV-related deaths, and zero stigma. This "getting to zero" vision has become the guiding framework for SF City as a whole. In this spirit, the HCPC and the GTZ coalition work with DPH to establish and implement priorities to improve outcomes along the HIV prevention, care, and treatment continuum.

To address syndemics and overlapping vulnerabilities, SF has also developed an **Ending the HIV/HCV/STI Epidemics (EtE) Plan**. SFDPH has extensive expertise and success convening broad-ranging community partners to develop and implement prevention and care plans. The CDC-PS19-1906 Ending the HIV Epidemic (EHE) planning process spurred further collaboration among SFDPH, the HIV Community Planning Council (HCPC), the SF Getting to Zero Consortium (GTZ), and End Hep C SF (EHCSF), and was the impetus for synthesizing existing plans into a cohesive framework. SF also convened the **EtE Steering Committee** that will continue during the 5-10 year Ending the HIV Epidemic implementation period to advise SFDPH on priorities and activities and ensure ongoing community representation.

Although not required by HRSA, in San Francisco, the HCPC coordinates **Part B** services in conjunction with Part A services to maximize the impact of these two funding streams. This service planning process is in turn coordinated with all relevant County units, including the Community Health Equity and Promotion and the Disease Prevention and Control Branches, in order to enhance regional efforts to identify and link to care persons with HIV who are unaware

of their positive status. At the same time, representatives of agencies receiving funds through Ryan White Parts C, D, and F play an active role on the Planning Council to ensure integration and coordination of EIIHA activities with other Ryan White-funded services.

c. Anticipated Outcomes of the Regional EIIHA Strategy:

The FY 2021 San Francisco EMA EIIHA Plan has **three** primary goals: **1)** to increase the percentage of individuals in Marin, San Francisco, and San Mateo counties who are aware of their HIV status; **2)** to increase the percent of HIV-positive individuals in our region who are effectively engaged in HIV care; and **3)** to reduce disparities in PrEP uptake, HIV infection, HIV testing, and successful and sustained linkage to care. SF EMA's EIIHA plan also includes approaches designed to reach the specific communities and individuals who are most vulnerable to HIV infection **before** they become infected. If GTZ is successful, the need for an early intervention plan should greatly diminish, because new infections will be virtually eliminated. These and other activities to be carried out by the San Francisco

The local EIIHA Plan directly incorporates the four key pillars, or strategies, highlighted in both the updated 10-year national HIV strategy entitled *Ending the HIV Epidemic: A Plan for America*, published in February 2020, and in the new Ryan White-funded *Ending the HIV Epidemic* funding opportunity recently published by HRSA. These pillars consist of the following:

- **Pillar One: Diagnose** all people with HIV as early as possible;
- **Pillar Two: Treat** people with HIV rapidly and effectively to reach sustained viral suppression;
- **Pillar Three: Prevent** new HIV transmission by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs); and
- **Pillar Four: Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Specific outcomes of the SF EMA EIIHA strategy are also codified as key **objectives** in both the updated 10-year strategy and the new Ending the HIV Epidemic funding opportunity. These include: a) reducing the number of new HIV infections in the US by 75 percent within the next five years; and b) reducing the number of new HIV infections in the US by 90 percent within 10 years, for an estimated totally of 250,000 HIV infections averted over that time.

The FY 2021 San Francisco EIIHA plan will reach many individuals who are disconnected from the system in order to bring them into HIV prevention, testing, linkage, and care services. Routine HIV testing, targeted community outreach, expanded case management services, and PrEP services specific to underserved communities will help to reduce disparities among groups such as MSM of color, substance users, African American women, uninsured and economically impoverished populations, homeless persons, and young MSM – all populations that have experienced historical HIV access and treatment disparities along with high rates of late HIV testing. The San Francisco EMA will utilize its EIIHA plan and matrix to focus on increasing awareness of HIV status and promoting treatment utilization among underserved populations as a way to continue to address HIV-related health disparities.

2. Legal Barriers and Solutions

Major current HIV-specific legal issues and accomplishments in California include the following:

- On September 26th, 2020, Governor Gavin Newsom signed into law AB 2218, groundbreaking new legislation which establishes a **Transgender Wellness and Equity Fund** within the California Department of Public Health for the purposes of funding holistic health services for transgender, gender non-conforming, and intersex (TGI) people across California, in part to address HIV-related disparities.
- In June 2019, US Senator Kamala D. Harris (D-CA) introduced the *PrEP Access and Coverage Act* in the US Congress, legislation that would dramatically expand Americans' access to **pre-exposure prophylaxis (PrEP)** medications;
- On September 13, 2019, California passed Senate Bill 159, which authorizes pharmacists to furnish PrEP, or pre-exposure prophylaxis, and post-exposure prophylaxis, or PEP, to patients **without a physician's prescription**;
- California Assembly Bill 362, most recently amended on April 23, 2019, authorizes the City and County of San Francisco (SF) to approve entities within their jurisdiction to establish and operate **overdose prevention programs (OPP**) for persons 18 years of age or older who satisfy the following specific requirements.

    - Availability of a hygienic space supervised by health care professionals where people who use drugs can consume pre-obtained drugs;
    - Provision of sterile consumption supplies, collection of used hypodermic needles and syringes, and provision of secure hypodermic needle and syringe disposal services;
    - Administration of first aid, if needed, monitor participants for potential overdose, and provision of treatment as necessary to prevent fatal overdose;
    - Provision of access or referrals to substance use disorder treatment services, medical services, mental health services, and social services;
    - Education of participants on the risks of contracting human immunodeficiency virus (HIV) and viral hepatitis; and
    - Provision of overdose prevention education and access to or referrals to obtain naloxone, proper disposal of hypodermic needles and syringes.

- California Senate Bill 233, signed into law by Governor Gavin Newsom on July 30, 2019, **prohibits the arrest of persons in the sex trade** who are reporting sexual assault, domestic violence and other violent crimes, or who are in possession of condoms.
- Current California law requires that every patient who has blood drawn at a primary care clinic, and who has consented to the test, be offered an HIV test that is consistent with the United States Preventive Services Task Force recommendations for screening for HIV infection. A bill passed in September 2016 created a pilot project, administered by the State Department of Public Health, to assess and make recommendations regarding the effectiveness of the routine offering of an HIV test in the emergency department of a hospital.

- On October 6, 2017, Governor Brown signed into law landmark legislation to reform outdated laws that had unfairly criminalized and stigmatized people living with HIV. Senate Bill 239 updated California criminal law to approach transmission of HIV in the same way as transmission of other serious communicable diseases. It also brought California statutes up to date with the current understanding of HIV prevention, treatment and transmission. The bill fulfilled a key goal of the National HIV/AIDS Strategy and is consistent with guidance from the U.S. Department of Justice and with California's "Getting to Zero" HIV transmission reduction strategy.
- At the current time, local health jurisdictions in California do not have access to data on prescribed PrEP medications for persons at risk for HIV. This makes it difficult to ascertain both the scope of PrEP treatment in our region, and the specific demographics of PrEP populations, which would in turn allow us to identify and address PrEP utilization disparities. The San Francisco EMA is supporting efforts to give access to PrEP prescription data for persons not currently infected with HIV, a shift that is made more likely with the advent of **PrEP Assistance Programs (PrEP-AP)** which help support the cost of PrEP medications for qualifying individuals.

3. Description of Target Populations

a. Why Target Populations Were Chosen:

To define and focus EIIHA activities, the following **three** populations will continue to serve as the key target groups for the FY 2021 San Francisco EMA EIIHA Plan:

1. **Males Who Have Sex with Males (MSM)**
2. **People Who Inject Drugs (PWID)**
3. **Trans Females Who Have Sex with Males (TFSM)**

All FY 2021 populations will be focused on using the special lenses of ethnicity, age, housing status, and general substance use.

The San Francisco EMA's FY 2021 EIIHA target populations have been selected on the basis of **three** key factors. **First**, from an epidemiological standpoint, these three populations together encompass at least **91.6%** of all persons currently living with HIV in the San Francisco EMA. MSM alone – including MSM who inject drugs – make up **85.3%** of all persons living with HIV cases in the region as of December 31, 2018, while non-MSM PWID make up another **6.3%** of all local PLWHA. **Second**, the populations represent the three groups most highly prioritized in the EMA's 2017-2021 Integrated HIV Prevention and Care Plan, a product of intense study and collaborative planning. And **third**, the selected populations contain the highest rates of new HIV diagnoses as reported through HIV testing data for the period January 1 - December 30, 2018.

b. <u>Challenges and Opportunities in Working with the Target Populations:</u>

Perhaps the greatest challenge as the region approaches zero new HIV infections and 100% viral suppression is the continued prevalence of disparities along the continuum of care. While strategies implemented to date have benefited white gay men, other populations have not seen the same degree of benefit. For this reason, the 2017-2021 Integrated HIV Prevention and Care Plan embraces a health equity approach to HIV prevention, care, and treatment as its focus going forward. The Plan includes numerous potential strategies to be considered by the merged Planning Council in addressing disparities, including:

- Implementing a pilot mentoring program for young gay men and trans females that supports the development and maintenance of personal strategies for supporting sexual health;
- Developing and implementing a standard HIV curriculum for substance use and mental health providers, including culturally competent approaches for screening for HIV risk and referral and linkage resources;
- Developing and disseminating PrEP Standards of Care through the San Francisco Department of Public Health, including standards on administering, tracking, and managing PrEP;
- Implementing DPH transgender-specific sex and gender guidelines that adhere to specific data collection principles including the following: 1) Naming should be self-identified; 2) Transgender and sexual orientation data should be coded with caution and care when working with minors in consideration of the fact that health data are legally accessible by guardians; 3) information should be up-to-date; 4) Naming should allow for both consistency and relevance and compliance and comparability;
- Exploring the creation of new program approaches to reduce HIV and hepatitis C infection among persons who inject drugs, including approaches that incorporate a harm reduction perspective;
- Developing and implementing new models for integrating geriatric specialists into the HIV clinic setting;
- Recognizing the growing shortage of physicians who are skilled in both HIV and geriatric care and advocate for the recruitment and training of specialists in these dual areas to address aging among HIV populations; and
- Creating a new level of specialized training and certification to create case management staff who are expert in the distinct system of services that exists for persons 50 and older.

As a direct result of the Plan, SFDPH is also expanding community engagement through an innovative series of **mini-grants for community-based organizations** that have deep connections to the populations of focus. These mini-grants will fund innovative approaches to harnessing and amplifying community voices in influencing HIV prevention and care efforts. The first round of grants, beginning later this year, will go to the following **five** organizations for the following programs: **SF Community Health Center:** Leading from Within for Trans women; **SF Community Health Center::** Leading from Within for People Experiencing Homelessness; **AIDS Project of The East Bay:** The Messenger Matters for Black / African-American communities;

Cause Data Collective: Community-based participatory action research for Latino/a/x communities; and **SF Drug Users Union:** Community Advisory Team for people who use drugs.

San Francisco continues to implement **Project OPT-IN** (Opt-In to Outreach, Prevention & Treatment) Initiative, specifically designed to reduce HIV-related disparities and health inequities across the spectrum of prevention, care, and treatment for **homeless populations living with and at risk for HIV.** The vision of Project OPT-IN is to create a network of homeless services that meets the needs of people living with or at risk for HIV, providing them with all the resources and support needed to stay HIV-negative or virally suppressed. Among other innovations, Project OPT-IN conducts homeless health outreach both at the individual level and through inter-agency partnerships, identify new or out of care persons experiencing homelessness who are living with or at risk for HIV, and collaborate with medical and social service providers to link and anchor these individuals in care. Project OPT-IN will improve HIV-related outcomes across the care continuum by providing services to address critical gaps in HIV prevention and care services for the target populations, while simultaneously working to transform systems and practices, thus reducing the long-term need for such services. San Francisco is also working toward becoming the one of the first cities in the US to implement an **overdose prevention consumption site** under the leadership of the city's mayor, London Breed. The site will provide a space for persons to inject drugs safely without fear of arrest, while accessing HIV testing and other supportive and treatment services. As noted above, San Francisco has also funded the development of the Micro-Elimination Plan to treat and eliminate Hep. C among residents with HIV.

c. <u>Strategies to be Utilized with the Target Populations:</u>

The San Francisco EMA will continue to employ a broad range of strategies to expand awareness of, access to, and utilization of HIV testing and care services in the service region for persons who are currently unaware of their HIV status and for persons with HIV who have dropped out of or become lost to care. These activities will be closely coordinated with activities conducted by the HIV prevention units in the three EMA counties as outlined in the integrated jurisdictional HIV Prevention Plans. All activities will also be coordinated to promote HIV prevention and care integration in the region.

Among many recent strategies introduced in our region, San Francisco has originated the highly influential and impactful **Rapid Antiretroviral Program Initiative for New Diagnosis (RAPID)** initiative**,** a program that began at Zuckerberg San Francisco General Hospital 3 years ago and has now expanded to HIV clinics citywide and has been adopted by other jurisdictions and metropolitan areas in the US. RAPID is a comprehensive initiative designed to help clients overcome the financial and social barriers to undergoing testing for HIV and being linked to care.[33] RAPID seeks to reduce the time between diagnosis, linkage to a primary care provider, antiretroviral initiation, and viral suppression. Through RAPID, five-day "treatment packs" are dispensed to new clients entering the clinic on the **same day** they have received an HIV diagnosis, while a full set of labs are drawn and the patient meets with a social worker to ensure coverage for the continuance of the ART medications. RAPID not only promotes patient health through early engagement in treatment, but plays a significant role in preventing new infections by reducing infectivity when patients are experiencing acute HIV syndrome, during

which they are at greatest risk to pass the virus on to others. The RAPID program is able to provide immediate medication linkage for clients linked at HIV testing sites throughout San Francisco, and has been extremely effective in helping the city meet its long-term test and treat goals.

Also at San Francisco General Hospital, a new medical program was introduced in early 2019 called **POP-UP (Positive-health Onsite Program for Unstably-housed Populations),** designed to provide flexible, comprehensive, and patient-centered care specifically designed to reduce health disparities among **homeless and unstably housed individuals living with HIV in San Francisco**. The program addresses the severe disparities in HIV health outcomes between housed and unhoused populations, including the findings in 2018 that in San Francisco, **75%** of housed persons were virally suppressed while only **33%** of homeless individuals were virally suppressed, and that homeless persons accounted for **14%** of new HIV diagnoses despite making up less than **1%** of the city's population. The POP-UP clinic sees HIV patients who are homeless or unstably housed who are not virally suppressed, and who come to the clinic for urgent care or health care needs of a **non-appointment, drop-in basis.** The program builds on our growing awareness that many patients with HIV who are unstably housed often do not keep regularly scheduled medical appointments, but often **do** visit the Zuckerberg San Francisco General Hospital Urgent Care Clinic when their own time permits. The POP-UP Clinic team consists of physicians, nurses, and a social worker who actively work together to provide care and coordination for this population. To create a low barrier to access care, POP-UP is open five days a week, on afternoons from Monday to Friday. No appointments are necessary and patients in this program may visit the clinic at any time without advance notice and receive care. POP-UP provides incentives for linkage and retention in care, enhanced patient outreach, and referral for emergency and permanent HIV housing. Based on its strong initial success, the POP-UP program is expected to be significantly expanded through funding to be proposed in the upcoming Ending the HIV Epidemic funding opportunity.

C. AIDS Pharmaceutical Assistance

N/A - The SF EMA no longer allocates Part A funds to support the purchase of HIV-related pharmaceuticals.

- **METHODOLOGY**

A. Impact of the Changing Health Care Landscape

1. <u>Overview of Regional Health Care Options:</u>

The most important complementary funding stream to support HIV care for populations with low incomes is the **Medicaid** system, or **Medi-Cal**, as the system is known in California. Medi-Cal is an indispensable link in the chain of support for persons with low-incomes and HIV in the San Francisco EMA, and it has become an even more fundamental component with the advent of expanded ACA coverage. According to the data supplied for this application by the California Department of Health Services Research and Analytic Studies Division, between July

1, 2017 and June 30, 2018, Medi-Cal fee-for service reimbursements for persons with HIV in the San Francisco EMA totaled **$80,695,334,** an increase of **35%** over the **$60,909,907** in Medi-Call fee-for-services in the SF EMA between July 1, 2014 and June 30, 2015, attesting to our success in bringing larger and larger numbers of low-income persons with HIV into the Medicaid system. Fully **45.2%** of FY 2017-2018 HIV Medi-Cal expenditures (**$36,440,088**) supported the cost of HIV-related medications, which represents a significant reduction from the **75.8%** of Medi-Cal expenditures that went to prescription drug costs only 3 years ago, in 2014-2015. Meanwhile, **13.6%** of Medi-Cal HIV funds supported long-term care in 2017-2018 (**$10,973,237**), up from **10.1%** in 2014-2015; **5.4%** supported hospital inpatient care (**$4,326,653**) and **2.9%** (**$2,343,693**) supported the cost of HIV care at clinics**.** The San Francisco Planning Council examines changes in Medi-Cal data each year and takes this information into consideration in making its annual allocation of Part A primary medical care funding.

In addition to expanding Medicaid enrollment through LIHP, California was one of the very first states to develop a **state-based health insurance exchange** authorized by the ACA, which was conditionally approved to operate by the U.S. Department of Health and Human Services in 2011. The exchange, named **Covered California,** is essentially a **virtual marketplace** that allows citizens and legally recognized immigrants who do not have access to affordable employment-based coverage and are not eligible for Medicaid or other public coverage to purchase subsidized health insurance if they earn up to 400% of FPL. Covered California health plans are also available to small employers through the Small Business Health Options Program (SHOP). In early 2013, the California Simulation of Insurance Markets (CalSIM) model predicted that at least 840,000 individuals with family incomes below 400% FPL would purchase insurance offered through Covered California and receive income-based premium tax credits to subsidize the out-of-pocket cost of coverage in 2014.[34] The vast majority of these individual are eligible for premium tax credits expected to range from 36% to 54% of enrollees in 2014.[35] However, during the historic first open-enrollment period from November 15, 2013 through April 15, 2014, more than **1.3 million** Californians chose health insurance through Covered California for coverage in 2014, while millions of additional Californians learned that they qualified for free or low-cost health coverage through Medicaid. Covered California today provides a critical bridge to affordable care for many persons with HIV in the San Francisco EMA whose incomes do not qualify them for expanded Medicaid coverage.

San Francisco residents have also had a longer-standing option of enrolling in the **San Francisco Health Plan,** a licensed community health plan created by the City and County of San Francisco that provides affordable health care coverage to over **100,000** low and moderate-income families. Created in **1994**, the San Francisco Health Plan's mission is to provide high quality medical care to the largest number of low-income San Francisco residents possible, while supporting San Francisco's public and community-minded doctors, clinics, and hospitals. Health Plan members have access to a full spectrum of medical services including preventive care, specialty care, hospitalization, prescription drugs, and family planning services, and members choose from over **2,600** primary care providers and specialists, **9** hospitals and over **200** pharmacies – all in neighborhoods close to where they live and work.

San Francisco also operates **Healthy San Francisco,** a program designed to make health care services available and affordable to uninsured San Francisco residents. Operated by the San Francisco Department of Public Health, Healthy San Francisco is available to all San

Francisco residents regardless of immigration status, employment status, or pre-existing medical conditions and currently provides health coverage to over **50,000** uninsured San Francisco residents. To be eligible for Healthy San Francisco, enrollees must be a San Francisco resident and have income at or below **400%** of Federal Poverty Level. Depending on income, enrollees pay modest fees for health coverage. The City and County are currently working with the State of California to finalize an effective integration between the two programs that ensures that persons with HIV wishing to transfer from Healthy San Francisco to Covered California are able to retain their current provider or that they have effective options for receiving high-quality HIV specialist care from culturally appropriate providers.

The San Francisco EMA also relies on insurance co-payment options available through the **California Office of AIDS Health Insurance Premium Payment Program (OA-HIPP)**, which pays health insurance premiums for individuals with health insurance who are at risk of losing it and for individuals currently without health insurance who would like to purchase it. Since the implementation of the Affordable Care Act, the OA-HIPP has experienced a **63%** increase in the number of clients served by the program.[36] As of June 2014, the last date for which statistics are available, a total of **913** OA-HIPP clients were being subsidized for health insurance provided through Covered California while another **1,095** were being subsidized for insurance outside the ACA system. Because of this support, neither San Francisco nor San Mateo County is currently providing co-payments for individuals newly covered through ACA. Marin County funds a small number of annual co-payments on an emergency basis to prevent individuals from losing insurance on a short-term basis.

a. <u>How Coverage Options Limit Access to Direct Health Care Services:</u>

While initial ACA implementation involved several significant barriers to immediate health care access, these barriers have largely vanished as agencies have become more adept at rapidly enrolling and retaining clients in insurance and as systems have adapted to accommodate new insurance options and requirements. Initially, for example, patients experienced significant delays due to being required to first change their medical home away from their existing HIV clinical site and then needing to subsequently re-designate that site as their specialty care provision center. Now, however, medical homes immediately assign new patients back to their HIV provider without a referral process. The expanding options afforded through ACA have increased the number of low-income persons with HIV in the SF EMA who are able to effectively access high-quality HIV care and support services whenever needed.

On the whole, Part A funding in the San Francisco EMA is able to address many of the direct care and support needs of low-income persons with HIV, including services for uninsured individuals and provide wraparound services that address shortfalls in Medicaid and other plan coverages. These resources are complemented by a range of public and private funds, including funds generated through the local Getting to Zero initiative. In regard to care services, additional funding for **mental health services, substance abuse treatment**, and particularly **housing** would have a tremendous impact on retaining HIV-infected populations in care.

2. Changes in the Health Care Landscape:

a. Service Provision and Complexity of Care:

The advent of health care reform and its aftermath has had welcome impacts on persons living with HIV in the San Francisco region. Expanded coverage has significantly broadened public insurance options for many low-income persons living with HIV who had formerly relied on the Ryan White system as their only source of funding for medical care and HIV treatment. While this initially created challenges for local HIV care providers in terms of enrollment, benefits counseling, and the exodus of some patients to local HMO systems, these impacts have now been largely absorbed, and the shift to new billing and insurance approaches has become routinized. Far from resulting in a reduction of low-income HIV patients at local clinics, the systemic change has in many cases increased the number of new clients seeking services in order to quality for ADAP funding to cover medication shortfalls in private insurance plans.

b. Changes in Part A Allocations:

The advent of the Affordable Care Act resulted in dramatic shifts in both the expenditure and allocation of Part A funds in the San Francisco EMA. For example, while requested costs for outpatient / ambulatory health service made up **39.3%** of the EMA's total Part A service funding request 7 years ago, for the 2014 Ryan White fiscal year, that percentage has dropped to only **7.2%** for the current FY 2021 funding request, including MAI funding. **This decrease is the result of a concerted effort by the SF EMA to streamline and consolidate direct HIV medical care costs while continually expanding third party reimbursements in order to maximize the value and impact of Part A contributions in relation to client retention and viral suppression.** For example, while medical case management costs needed to retain individuals in care and adherent to HIV medications made up only **9.1%** of requested Part A funds in FY 2014, they now make up **24.5%** of the current Part A service funding request. Similar proportional funding increases have taken place in regard to mental health services (**8.7%** in FY 2014 vs. **11.3%** in FY 2021) and non-medical case management (**3.3%** in FY 2014 vs. **16.6%** in FY 2021). Expanded ACA-related reimbursements directly led to the EMA's decision to successfully apply for an annual waiver of the 75/25 primary care funding requirement beginning in FY 2014, in order to shift expenditures that had formerly gone to support Core Medical Services into support for essential Support Services that play a critical role both in retaining persons with HIV in care and ensuring better long-term medical adherence.

B. Planning Responsibilities

1. Planning and Resource Allocation:

a. Description of the Community Input Process:

As in previous years, and despite the COVID-19 epidemic, the San Francisco EMA continued to employ a **multi-phased process** for FY 2021 priority-setting and allocations. This process

began early in the year with planning meetings of the HIV Community Planning Council's Steering Committee to assess preliminary data and develop a set of initial prioritization recommendations. Planning Council members also conducted a review of progress toward the Objectives and Action Steps contained in its 2017-2021 Integrated HIV Prevention and Care Plan. A broad range of reports, updates, and background information was also presented to the Council to ensure all had a deep understanding of the current service access, care outcomes and disparities, and funding trends in the EMA. In May 2020, for example, the Council heard a presentation by HIV Health Services on its current Continuous Quality Improvement (CQI) initiatives and outcomes, and in June 2020 the Council discussed Ryan White Part A eligibility criteria in light of severe need and special populations. The Council's formal annual Prioritization and Allocation Summit took place on September 28, 2020, preceded by discussion of resource allocation scenarios during committee Meetings on September 2, 8, 10 and 17. place in October 2019. The Council's FY 2021 funding recommendations took into account a wide range of trends and factors in the EMA, including review of epidemiological information, client data, emerging impacts of COVID-19, and HIV funding in the EMA, including Ryan White and Medicaid funding. During the Prioritization and Allocation Summit, the Council also discussed funding scenarios to deal with either with potential increases or decreases in Part A funding.

Since its inception, the San Francisco Planning Council has employed the broadest possible range of quantitative and qualitative HIV data to help Council members assess needs, measure progress, identify gaps, prioritize services, and allocate resources. The Council has also consistently incorporated broad-based consumer participation to arrive at a balanced and effective set of goals and objectives to improve the region's comprehensive system of care. The Council has placed a historical emphasis on **health equity and elimination of health disparities**, focusing on effectively meeting the needs of **underserved populations** and developing care systems that facilitate entry and retention in care for these groups. This approach is consistent with the overall purpose of Ryan White funding, which is to develop systems that allow highly underserved individuals to access high-quality HIV care, treatment, and support services regardless of income status. The San Francisco EMA's entire model of care is structured around the need to ensure access to care for underserved populations, including its **Centers of Excellence** program, which is specifically designed to address retention and care access barriers for underserved groups with special needs such as homeless persons, women, African Americans, Native Americans, Latinx populations, transgender persons, and recently incarcerated individuals. Centers of Excellence service data consistently attest to the success of this approach in achieving high care representation among groups who most commonly face barriers to health care access in America, including low-income individuals and families, persons of color, women, gay and bisexual men, transgender persons, active substance users, homeless individuals, and persons with mental illness. The Council continues to use its success in meeting the needs of these populations as a benchmark for tracking its own effectiveness in addressing the goals of the Ryan White program.

i. <u>How PLWH are Involved in the Planning and Allocation Process:</u> As in previous years, persons living with HIV (PLWHs) were integrally involved in all phases of the FY 2021 priority-setting and allocation process. The new merged Planning Council includes **17** self-identified

persons living with HIV, comprising **44%** of total Council membership. Council bylaws require that at least **one** new Council Co-Chair be a person with HIV and a consumer of Ryan White services, and the Council strives to ensure that at least one co-chair for each committee is a person with HIV.

The Council also relies on a series of **issue and population-focused needs assessments** that replaced the comprehensive needs assessment process that was last conducted in our region in 2008. Since 2010, the Council has commissioned and conducted needs assessments on populations experiencing health access and outcomes disparities in the region, including **Transgender Women** (2012); the **HIV and Aging Population** (2013); **Latinx MSM** (2103); **MSM Users of Crystal Meth** (2104); **Asian & Pacific Islanders** (2015); **African-Americans** (2015); **Clients with Mental Health Challenges** (2016); **HIV-Positive Homeless and Unstably Housed Persons** (2017), and **HIV-Positive Substance Users** (2019). Each needs assessment utilizes a range of methodologies such as focus groups, surveys, and key informant interviews and includes a summary of recommendations which the Council uses to discuss needs and issues around specific topic areas and populations to influence the prioritization and allocation process. In the case of the HIV-Positive Substance Users Needs Assessment, for example, a total of **94** HIV-positive consumers provided direct input into the study's findings and recommendations, including **15** individuals in focus groups and **79** individuals in one-on-one interviews. The smaller-scale needs assessment approach allows the Council to focus on current and emerging issues and populations as they arise, in order to provide relevant and rapid responses to local needs.

ii. How Community Input Was Considered and Applied: The Planning Council's current process of conducting annual, issue-focused needs assessments facilitates wide-ranging and consistent input by HIV-infected and affected consumers into the Council's prioritization and allocation decision-making. Each Planning Council meeting also incorporates structured, set-aside time for community comments and input in association with each decision-related agenda item. Each year, the Planning Council also receives and considers specific recommendations from the **San Francisco HIV Provider Network**, a group of **43** community-based, non-profit HIV service agencies in the San Francisco EMA meeting the needs of persons living with HIV. Additionally, the Council considers annually cost of living increases related to both costs and expenses of HIV care, and hears a report from the **HIV Consumer Advocacy Project (HCAP),** a unique program in SF that provides assistance to clients in filing grievances with Ryan White Part or B providers and that helps to resolve problems before they become formal grievances.

iii. How MAI Funding Was Considered: As in previous years, the Planning Council reviewed a comprehensive summary of the specific services currently funded through Minority AIDS Initiative funding, and will incorporate MAI allocations decisions into its overall FY 2021 allocations process. The summary details specific goals of the local MAI process; historical funding levels received in the region; previous and current expenditures with that funding; specific outcomes achieved in regard to minority health, health access, and service utilization; and a quantified report on the demographics of populations served through MAI funding. This year's report continues to validate the success of the EMA's approach to MAI allocations, and

affirmed the key role that MAI funding plays in helping reduce HIV disparities while meeting the needs of historically underserved populations.

iv. How Data Were Used in Priority Setting and Allocation: The Planning Council receives and reviews a broad range of high-quality data – including unmet needs data – to assist in prioritizing Part A services and allocating resources, with an emphasis on HRSA-identified core medical services. Among the data presented, reviewed, discussed, and incorporated by the Council in its decision-making this year have been the following:

- Background information on requirements and parameters of the Ryan White HIV Treatment Extension Act of 2009, including definitions of core service categories;
- A detailed analysis of each priority service category funded and not funded by the Council in FY 2020 by county, including service definitions; budgeted and actually funded service category amounts; populations served; key points of entry; utilization reviews; other funding sources available in each category; and possible impacts of cuts in each service category;
- A comprehensive, updated 2019 HIV Epidemiology Report by the SF Population Health Division detailing current PLWH populations and discussing current trends in the epidemic;
- A summary of findings from the most recent needs assessments commissioned by the Planning Council, including the Comprehensive Assessment and Follow-Up Qualitative Study;
- A summary estimate of unmet need among PLWH in the San Francisco EMA utilizing the EMA's most recent HIV care continuum data;
- A detailed presentation on other funding streams in the EMA, with a special focus on federally funded programs and on programs funded through MAI support, as well as Part B, Part C, Part D, and Part F funding through the San Francisco Department of Health, and other sources;
- A review of goals and objectives from the 2017-2021 Integrated Prevention and Care Plan; and
- Consensus input to the Planning Council from the San Francisco HIV Provider Network, a group of **43** community-based, non-profit HIV service agencies in the San Francisco EMA meeting the needs of persons living with HIV.

v. Significant Prioritization and Allocation Changes from FY 2020 to FY 2021: Apart from the continuing, multi-year trend of shifting Part A dollars from direct medical care services to services that support patient retention in care, no significant prioritization and allocation changes took place between the current Part A fiscal year and the upcoming 2021 fiscal year. However, as a direct result of ACA implementation, the Council has successfully applied for a waiver of the 75/25 Part A core medical services funding requirement each year since 2014, and plans to do so for the upcoming 2021 fiscal year as well, although new guidelines for this process have not yet been received at the time of this writing. The waiver request is in direct response to the declining demand for Part A funding to support ambulatory outpatient care as a result of increased ACA-related reimbursements. The FY 2021 funding request continues a pattern of reductions in the proportion of Part A funding requested to specifically support outpatient medical care.

2. Administrative Assessment:

a. Assessment of Grant Recipient Activities:

In 2017, the San Francisco EMA HIV Community Planning Council conducted a comprehensive assessment of the regional Ryan White Part A grantee agency, the San Francisco Department of Health Services HIV Health Services unit. This marked the first time that the Council had undertaken a formal assessment in over half a decade. The assessment involved **four** key Part A constituent groups: a) Part A-funded providers; b) Planning Council members; c) Planning Council staff; and 3) Staff of San Francisco HIV Health Services (HHS). The methodology for the assessment included an anonymous, online survey for all participants; key information interviews involving HIV service providers; and a series of 3 focus groups, one each involving Council members, Council staff, and Grantee staff.

The overall response to the work of the local Part A grantee was extremely positive. Several members of the Council referred to the relationship between the Council and HIV Health Services as a **partnership,** with Council members reporting a high level of transparency from the Grantee. Several Council members commented on the value of having HHS representation at every meeting. Aggregated Council responses to the online survey were as follows:

Survey Question	Total Score out of 5
How well does the grantee support the Council?	**4.75**
How timely and complete are presentations or information presented by grantee staff?	**4.33**
How well does HHS support the prioritization & allocation process?	**4.25**
How timely, well-prepared, and helpful are the presentations brought to the Planning Council by grantee staff?	**4.25**
How well does HHS support the process of allocating carry-forward dollars?	**4.50**

Consensus findings of the Administrative Assessment across all input group consisted of the following:

- Key stakeholders across the board defined their relationship with the grantee as a partnership, and expressed appreciation for a high level of responsiveness and a general spirit of shared vision.
- Council members and council staff emphasized the importance of grantee transparency in the allocation process, and expressed confidence that services funded by the grantee address the Council's priorities and instructions for allocating dollars.

- Providers reported concerns around the long and complicated process of contract certification, but reported no adverse impact on clients due to delays in reimbursement.
- Providers reported a high level of responsiveness from HHS and CDTA, and reported that the procurement and monitoring processes are fair.
- The grantee self-assessed the administrative mechanism as very effective, and expressed an openness to receive feedback and a desire to continually seek improvement.

The Council conducted a new Administrative Assessment beginning in late 2018 which was completed in late 2019. Results are expected to be delivered to the HIV Community Planning Council during the Council meeting of November 23, 2020.

b. Strategies to Address Deficiencies:

Because the Planning Council's Administrative Assessment did not identify any deficiencies in its assessment of grant recipient activities, **no** corrective actions needed to be taken in response to assessment findings.

3. Letter of Assurance from Planning Council Chairs:

Please see Planning Council letter in **Attachment 6.**

4. Resource Inventory:

a) Coordination of Services and Funding Streams:

i. Jurisdictional HIV Resources Inventory: Please see table in **Attachment 5.**

ii. Narrative Resource Inventory Description: The San Francisco HIV Health Services Planning Council and the SF Department of Public Health work together to ensure that Ryan White Part A funds are coordinated across all applicable funding streams in the region and that they address identified service gaps at all levels of client care and support. The Planning Council reviews annual service category summaries that include a detailed listing of all Ryan White and non-Ryan White funding sources for each category, including sources such as ADAP, Medicaid and Medicare support, public entitlement programs, private insurance and HMO support, Veterans Administration programs, City and County funds, HOPWA and SAMHSA grants, and State mental health funds. The Grantee also ensures that services are coordinated to maximize accessibility of services, while seeking every possible alternate source of funding apart from Part A to support HIV care.

The San Francisco EMA is also dedicated to ensuring the integration and coordination of **all** sources of Ryan White funding in the region. The Health Services Planning Council prioritizes the use of Ryan White funds for services that are not adequately funded through other reimbursement streams to ensure that Part A funds are the funding source of last resort. During each year's priority setting and allocation process, the Grantee produces detailed fact sheets on each service category that include a listing of **all** other funding streams available for that

category, including Parts B, C, D, and F programs, ADAP, and MAI funding. The Planning Council also assists in the planning for Part B-funded services. The Planning Council works with other local planning groups such as the Long-Term Care Coordinating Council to coordinate services and eliminate duplication.

- **WORK PLAN**

A. HIV Continuum Table and Narrative

1. HIV Care Continuum Table: Please see table in **Attachment 7.**

2. HIV Care Continuum Narrative:

a. How the Care Continuum is Utilized in Planning and Prioritization:

The continuum of care framework embodies an approach to comprehensive care which has an increasingly important impact on integrated HIV prevention and care service planning in the San Francisco region. The Continuum of Care sets clear benchmarks to track our progress toward key HIV outcomes in the region, and allows us to compare our own regional outcomes to outcomes in other health jurisdictions. At the same time, analysis of continuum-related disparities shows us where we are falling short in terms of reaching and serving specific HIV-affected subpopulations and serves as a guide to allow us to more effectively allocate resources to eliminate disparities and achieve health equity. The Planning Council reviews the region's most recent Continuum of Care during its annual prioritization and allocation process - along with a corresponding disparities analysis - to ensure that its funding strategies will continue to have the greatest impact on all aspects of the Continuum, with the ultimate goal of achieving viral suppression among the greatest possible number of PLWH in our region.

At the same time, the Continuum reflects and enhances a **merged vision of HIV prevention and care** which is embodied by our region's recent merger of our former HIV care and prevention planning councils into a single merged planning body - the San Francisco HIV Community Planning Council. The Council's philosophy and approach builds from the concept of **treatment as prevention** in order to address HIV as a **holistic health issue**. This approach sees HIV prevention, care, and treatment as being **inextricably intertwined**, and prioritizes the needs of people **regardless of HIV status**. This creates a context that allows affected communities to come together around a common vision and set of priorities, including ensuring access to health care and other services; providing a continuum of HIV prevention, care and treatment services using a holistic approach; and ultimately, as a result, "getting to zero" - meaning zero new infections, zero AIDS-related deaths, and zero stigma – may be within our reach for the first time in the history of the epidemic.

b. How the Impact of the HIV Care Continuum is Evaluated:

The merged San Francisco HIV Community Planning Council hosts regular presentations and updates on the local continuum by staff of the San Francisco Department of Public Health

and considers disparities in continuum outcomes in regard to sub-populations when making prioritization and allocation decisions and planning prevention strategies and services. The Department itself utilizes continuum outcomes as a strategy to assess the effectiveness of the local prevention and care system in meeting existing and emerging prevention and care needs, and to plan enhanced services and programs to better address shortfalls in continuum targets.

B. Funding for Core and Support Services

1. Service Category Plan:

a) Service Category Plan Table: Please see table in **Attachment 8.**

b) MAI and Overall Service Category Plan Narrative:

The FY 2021 Part A Plan requests a total of **$15,739,556** in Formula and Supplemental funding to allow the SF EMA region to continue to meet escalating client needs in an effective and strategic manner. This represents a **2.4%** reduction from the **$16,126,350** requested by the EMA for the 2020 Ryan White fiscal year. Direct service allocations make up **88.3%** of this request, for a total of **$13,892,409**. Another **$367,490** supports EMA-wide quality management activities, while **$1,479,6678** supports administrative costs for the recipient agency, including San Francisco Planning Council expenses. Reflecting HIV caseload proportions in the EMA's three counties, approximately **9.2%** of the FY 2021 direct service request is expected to support HIV client services in **San Mateo County**, while another **3.5%** is expected to support direct HIV services in **Marin County**. The remaining service allocation supports persons living with HIV in the City and County of San Francisco.

The large majority of proposed FY 2021 service expenditures – **60.8%** of total requested service dollars (**$8,440,768**) - supports the provision of direct care services in HRSA-identified **core service categories**. Of this year's total direct service request, a total of **$1,000,436** is requested for **outpatient / ambulatory health services** (including **$451,648** in Part A MAI funds), an amount representing **18.4%** of the total core services request. This category includes support for ambulatory care services delivered in community and institutional settings as well as the **seven regional Centers of Excellence** that build upon and enhance San Francisco's highly successful integrated services approach to care. Additional HRSA core categories for which significant funding is requested in the FY 2021 Plan include: a) **Medical Case Management** which links and coordinates assistance from multiple agencies and caregivers in order to ensure access and promote retention in care and adherence to medical treatment (**$3,404,966,** including **$207,890** in requested MAI funds); b) **Mental Health Services,** including Crisis and Outpatient Mental Health Services (**$1,570,461**); c) **Oral Health Care** to address critical dental manifestations of HIV and preserve overall client health (**$857,829**); d) **Hospice Services** supporting room, board, nursing care, counseling, physician services, and palliative care for clients in terminal stages of illness (**$851,008**); e) **Outpatient Substance Use Treatment Services** to allow clients to attain the stability needed to effectively adhere to HIV treatments and medications (**$285,463**, including **$87,941** in MAI funds); and f) **Home Health Care** to meet direct medical treatment needs outside of inpatient and clinical settings (**$284,545**).

The San Francisco EMA utilizes Part A MAI funds specifically to support services for low-income HIV-infected Latinx populations. While some service dollars incidentally support other populations of color with HIV, local MAI funds are almost exclusively focused on ensuring culturally and linguistically appropriate services to this large and rapidly growing PLWH population. Latinxs are the fastest growing group of HIV-infected persons in the EMA by ethnicity, making up **40.1%** of all new HIV diagnoses in CY 2019 alone, despite comprising only **18.9%** of the EMA population. Between 2011 and 2019, the number of Latinx PLWH in the SF EMA grew by **56.1%**, from **15.5%** to **24.2%** of total PLWH. According to the Pew Research Center, **29%** of Hispanics in California lack any form of health insurance and **25%** of Hispanics 17 and under live below the Federal Poverty Line.[37]

The primary manner in which MAI funds ensure quality care access for communities of color is through funding of the **Mission Center of Excellence** that has been established in the heavily Latinx Mission district by **Mission Neighborhood Health Center.** The Mission CoE addresses what is both the fastest growing and one of the most highly impoverished communities in San Francisco in terms of HIV infection. The Center provides culturally competent, integrated, bilingual/bi-cultural medical and health services to community members living with HIV, with an emphasis on Spanish-speaking Latinx clients. In addition to supporting the cost of direct medical/ambulatory health services through a staff of five bilingual/bicultural professionals, MAI funding helps support the cost of medical case management, mental health counseling, and substance abuse services. MAI-funded peer and treatment advocates also help clients make informed decisions about medications, and work with them to identify and remove barriers to adherence.

Minority AIDS Initiative funds have had a major impact on the San Francisco EMA, allowing us to identify, reach, and bring into care a significant number of highly disadvantaged persons of color, in turn reducing service disparities and improving health outcomes across the region. FY 2019-2020 Part A MAI funding enabled the EMA to provide critical medical, case management, and primary services to **over 320** impoverished clients of color, many of whom are transgender persons. MAI funding has enabled the San Francisco system of care to be well-positioned to address the growing care needs of disproportionately impacted Latinx populations, including Latinx MSM.

- **RESOLUTION OF CHALLENGES**

Please see table beginning on the following page.

Challenges & Barriers	Proposed Resolutions	Intended Outcomes	Current Status
▪ **Continually evolving impacts of the COVID-19 pandemic, including decreased State and County funding for HIV services**	▪ Continue to track impacts of the COVID-19 pandemic in regard to state and county income and budgeting and on the lives and health of low-income persons living with HIV ▪ Conduct ongoing contingency planning to deal effectively with both potential budget cuts and with increased client demand for services based on reduced income and unemployment	▪ Respond effectively to changes in the HIV care and support system with minimal disruption for clients ▪ Maintain the highest possible level of ongoing client service and support by prioritizing service and support needs throughout the EMA and shifting resources as needed	▪ At the present time, the COVID-19 crisis has already resulted in the inability of EMA County governments to support any reduced or de-funded Part A services, leading to significant shifting of resources in the current FY 2021 Part A funding request ▪ The SF Planning Council continues to monitor the situation and conduct contingency planning to deal with a range of potential future scenarios
▪ **Rapidly aging population of persons 50 and older with HIV**	▪ Continue to develop models of enhanced geriatric assessment and care in HIV clinical settings ▪ Expand linkages between geriatric and HIV service communities ▪ Expand consumer involvement in designing and implementing effective support programs for older PLWH ▪ Explore opportunities to meet the unique psychosocial and behavioral support needs of aging, long-term survivors of HIV.	▪ Improved health outcomes of older PLWH ▪ Enhanced long-term retention of older adults with HIV in care ▪ Improved access to community aging services and resources for older PLWH	▪ SF recently completed the Silver Project, a demonstration project to incorporate expanded aging assessment and geriatric consultation in HIV clinical settings ▪ Ryan White funds have helped support the creation of an aging specialty clinic at Zuckerberg SF General Hospital ▪ Ryan White Part D funds have been requested to launch the nation's first specialty clinic for older women with HIV at SF General Hospital
▪ **Continued high impact of HIV among homeless populations**	▪ In February 2017, the SF Planning Council's Community Engagement Committee formed a Homeless and Unstably Housed Needs Assessment Work Group to identify needs of homeless persons with HIV ▪ In September 2017, the Work Group presented findings of a Homeless and HIV	▪ Earlier identification and linkage to care of homeless persons with HIV ▪ Expanded long-term retention in care to enhance viral suppression outcomes ▪ Improved access to safe and affordable housing with	▪ SF recently completed a five-year HRSA SPNS grant to develop and test a new integrated system of HIV care and support for homeless PLWH ▪ SF identified funding to continue key aspects of the multi-service clinical model developed through the SPNS grant

Challenges & Barriers	Proposed Resolutions	Intended Outcomes	Current Status
	needs assessment involving input from 74 unstably housed PLWH ▪ SFDPH incorporates training and TA on enhanced identification and service to homeless PLWH in ongoing subcontractor support activities	behavioral support services to preserve health and wellness ▪ Provision of multiple services in accessible, culturally appropriate settings	▪ The SF Planning Council incorporated recommendations from the Homeless and Unstably Housed Needs Assessment Work Group in the FY 2019 prioritization and allocation process
▪ **Need to ensure long-term care retention and medication adherence for persons with complex needs**	▪ Continue to utilize medical and non-medical case management staff to assess client needs and identify and address barriers to care ▪ Develop new methods for pro-actively identifying and working with clients who are at risk of falling out of care ▪ Explore new methods for expanded involvement of consumers and peers in clinic-based client retention support roles	▪ Ensure ongoing, long-term medication and adherence and care retention to preserve and expand high levels of viral suppression and continue progress toward reduced HIV cases ▪ Address long-term medication fatigue, particularly among high-risk populations such as young people, transgender persons, homeless persons, active substance users, and persons with mental illness	▪ SFDPH supports subcontracted agencies in developing new methodologies for pro-actively identifying and supporting clients at risk of dropping out of care, including targeting long-term clients who are not virally suppressed ▪ The SF Planning Council prioritizes Part A funding to support long-term care retention and medication adherence activities. ▪ SF assigned local General Funds to create and support a mobile-engagement based Integrated Case Management program to provide a higher level of support for high acuity clients to retain retention in care.
▪ **Need to better track pre-exposure prophylaxis (PrEP) use in order to identify and address PrEP disparities**	▪ Develop expanded methodologies to track PrEP utilization within public and non-publicly funded medical and clinical settings, including demographic information on PrEP users ▪ Involve consumers in planning effective PrEP education, outreach, and linkage activities to reach underserved subpopulations	▪ Better knowledge of which subpopulations are and are not using PrEP in order to effectively target PrEP outreach, education, and resources ▪ Better knowledge of effective ways to recruit subpopulations that are under-utilizing PrEP ▪ Access to region-wide data on utilization of PrEP medications	▪ SFDPH continues to reach out to public and non-publicly funded clinical providers throughout the EMA to obtain a better picture of the number and characteristics of persons enrolled in PrEP in the region ▪ The SF EMA continues to support new State regulations that will allow access to data on PrEP pharmaceuticals for HIV-negative persons

Challenges & Barriers	Proposed Resolutions	Intended Outcomes	Current Status
	▪ Continue to advocate for new State regulations that allow reporting of PrEP medication prescriptions for HIV-negative persons		
▪ **Need to better enhance HIV identification and tracking systems in San Mateo and Marin Counties**	▪ Provide support through SFDPH for enhanced case finding efforts in San Mateo and Marin Counties, including better identification of high-risk areas and populations ▪ Provide support through SFDPH for enhanced epidemiological tracking systems to better monitor outcomes and outcome disparities in the two counties	▪ Improved HIV prevention and outreach in San Mateo and Marin Counties ▪ Improved HIV case data in the two counties ▪ Enhanced integration of HIV data across the EMA, resulting in production of a reliable EMA-wide Care Continuum chart	▪ The five-year Integrated HIV Prevention & Care Plan incorporates specific, five-year targets for supporting San Mateo and Marin Counties in enhancing case finding and tracking systems ▪ Planning Council Plan monitoring incorporates tracking of systems enhancement in the two counties throughout the life of the Plan

- **EVALUATION AND TECHNICAL SUPPORT CAPACITY**

A. Clinical Quality Management (CQM)

1. <u>Using Performance Measures to Analyze and Address Disparities:</u>

The San Francisco EMA maintains a well-established quality management infrastructure that enables consistent analysis and problem solving of issues related to client care and to lack of equity in regard to HIV care outcomes. The **Director of HIV Health Services,** Bill Blum, oversees the creation, implementation, and evaluation of continuous quality improvement (CQI) activities that are in turn supervised and managed by the **Center for Quality Improvement and Innovation.** The SF DPH **HIV Health Services Continuous Quality Improvement Committee**, comprised of members with diverse perspectives on quality of care, is responsible for selecting and implementing a targeted and specific CQI effort for Ryan White Part A funded providers annually and updating the local Quality Management Plan. The Committee also prioritizes and implements new QI projects; provides continuous QI and topical training; responds to providers' needs by utilizing the **Center for Quality Improvement and Innovation**'s (CQII) Quality Indicator measures and tools; and updates performance indicators to satisfy quality measures. The chart below briefly outlines responsibilities of staff and committees involved in the EMA's quality improvement efforts (see **Figure 16**):

Figure 16.
Chart of Responsibilities for SF EMA Clinical Quality Management Program

Individual / Entity	Role / Responsibilities
▪ **HHS Director**	▪ Provides fiscal oversight; approves overall plan; reviews and tracks implementation of work plan.
▪ **HHS Assistant Director**	▪ Coordinates with CQI committee to develop goals, design and implement work plans; directly supervises HHS CQI staff.
▪ **Quality Improvement Coordinator**	▪ Coordinates operations of CQI; assists in overall QI development; generates analyses and reports; oversees day-to-day development of program; shares QI performance reports with providers and the local HIV Community Planning Council; attends planning meetings; reviews existing literature related to quality development and improvement; coordinates capacity building activities.
▪ **HHS ARIES Team**	▪ Monitors HHS ARIES Database; monitors client and service level data compliance standards; assists in designing CQI plans; advises on performance indicators; creates reports from raw data; analyzes and reports on CQI results; trains and updates provider users as needed.

Figure 16. Chart of Responsibilities for SF EMA Clinical Quality Management Program	
Individual / Entity	**Role / Responsibilities**
▪ **San Mateo and Marin Co. QI Representatives**	▪ Oversees all Quality Management activities in their counties and respective providers.

To effectively track and address local HIV-related care and outcomes disparities, several critical aspects of care are monitored throughout each contract year, including primary care health QI outcomes, client services data, The San Francisco EMA utilizes the HRSA HAB performance measures tracked through ARIES. Reports on the various performance measures are generated on a routine basis and delineate both the aggregate data for the EMA and agency-specific data for the Centers of Excellence and other core medical services programs. This data allows the EMA to assess tracking of health outcomes and evaluate system-wide or agency-specific issues in both client care and data collection. System-wide issues are discussed with the Director of HIV Health Services, the Quality Improvement Coordinator, data collection specialists at HIV Health Services, and providers at the monthly Centers of Excellence meetings. These meetings serve as a forum for discussing care-related issues and performance measures and are attended by the QM consulting staff. Additionally, ARIES-generated QI data are utilized to measure program performance objectives standardized across several service categories such as Ambulatory/Outpatient Health Services, Medical Case Management, Mental Health Services, Hospice, and others.

As noted above, key coordination and oversight of the local QM process is carried out by the Quality Improvement Coordinator, who has responsibility for planning and implementation of activities related to the EMA's quality management program, which is focused on achieving health equity across all HIV subpopulations. Additional consultants conduct a variety of activities such as developing training curricula for new standards of care; leading and presenting trainings in standards of care and other relevant topics. To track indicators, HIV Health Services establishes benchmarks with each agency at the beginning of each contract period and provides training and technical assistance to ensure that agencies understand and are able to meet ARIES data reporting requirements. HHS has also disseminated an ARIES Procedural Guidelines for Client Outcome Objectives Reportage to all primary care and medical case management service providers. HIV Health Services aggregates agency data to track progress toward stated indicators and discusses variations with agencies when they are identified. HHS also works with agencies to collaboratively develop remedial responses to ensure adherence to quality standards.

The San Francisco EMA's well-established Quality Management infrastructure enables consistent analysis and problem solving of issues related to client care. The Director of HIV Health Services oversees the creation, implementation, and evaluation of QI activities that are in turn supervised and managed on a day-to-day basis by the HIV Health Services Assistant Director, with support from the Administrative Analyst, the HHS Quality Improvement Coordinator, and the ARIES Site Manager. Under these individuals' supervision, and in collaboration with providers, quality components are developed and implemented in

collaboration with other services and administrative staff from the selected programs. Additionally, consultants with a wide range of diverse skills and expertise may support the QM program through the provision of services such as training, technical assistance, program evaluation, and administrative support.

Since the end of Ryan White 2018-19 Fiscal Year, HHS has been implementing a CQI initiative specifically focused on improving viral load suppression among African American clients. The HHS CQI Committee has convened monthly meetings of a broader CQI Committee made up of HHS-funded Primary Care, CoE, and Medical Case Management providers to focus on both their individual efforts to address health equity related to African-American viral load suppression (VLS), and to discuss system-wide efforts to work jointly toward implementing as well. In total, **11** different programs send key staff to the **"Improving African-American Viral Load Suppression Equity" Committee** which meets every other month. As of September 2020, clinical data collected by the committee indicated that **five** programs have a need to increase VLS among only **one** of their African-American clients in order to achieve equity within their program. In total, the committee has established a targeted goal of **43** African-American clients across **11** programs achieving VLS in order to reach and maintain health equity for this CQI measure.

HIV Health Services also distributes an **annual training needs assessment survey** to Part A-funded agencies to identify training needs and prioritize quality management projects and improvement areas within the regional Ryan White system in relation to HIV disparities. In addition to the training needs survey, continual agency monitoring also provides an opportunity for HHS to identify areas for quality management improvement among providers. Through established processes, HHS staff alert the Quality Improvement Coordinator whenever a problem or issue is identified, and an agency assessment is quickly initiated. Based on this assessment, a **technical assistance plan** is developed and implemented in collaboration with the agency to provide skills-building and support for improving client care. Regular assessments of subcontractor agencies include a review of the current and previous year's RSR data completeness report; a review of the agency's data flow processes; identification of key staff who collect data; where collected data are stored; how programming is created so that data can be mapped and imported into ARIES; and who reviews ARIES data quality. Data elements and/or indicators that fall short of compliance standards are specifically examined for all QI projects. HHS encourages the utilization of **Plan-Do-Study-Act (PDSA) cycle models** for quality improvement projects at individual agencies. In June of 2017, HHS utilized a trainer from the National Quality Center to conduct a training for Ryan White Part A funders on strategies for improving their CQI activities at their individual programs. In the summer of 2019, HIV Health and the providers with whom they were working on a year-long Ryan White Part B CQI were awarded the **2019 Center for Quality Improvement and Innovation (CQII) Leadership in Quality Award** by the California State Office of AIDS for their work to improve retention in care and viral load suppression in conjunction with a food / delivered meals community provider by working to identify food clients not engaged in care and not virally suppressed and utilizing a PDSA process to create an effective warm-hand off structure to link these clients to medical case management and primary care.

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

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

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

2. <u>How CQM Data Is Used to Improve or Change Service Delivery:</u>

Current indicators as well as program performance objectives are reviewed by the CQI Committee to ensure specificity, relativity, accuracy, and traceability to the needs of clients and to identify and help develop strategies to address HIV-related health disparities, especially in regard to Viral Load Suppression, engagement in care and percent of clients prescribed ART. Data analysis is initially prepared by HHS staff with input from the other EMA county staff for verification of findings. Data reviews also take place during HHS provider meetings. Data analysis continually incorporates comparison with epidemiologic and care continuum data to identify progress toward reducing disparities, and to plan responses to disparity issues. Meanwhile, HHS staff provide ongoing updates and information on quality management activities to the San Francisco HIV Community Planning Council. The HIV Health Services QI Coordinator provides regular formal progress reports to the Council on the status of the quality management program and the client-level data system. HHS prepares an annual EMA CQI presentation which consists of a description of all indicators including national and local threshold performance goals; a graphic depiction for each which illustrates aggregate results by county; an analysis of data findings; a statement of whether or not performance goals were met; and reasons if not met and next steps for quality improvement. In addition, a ten-year trend chart of the QM indicators is shared on at least an annual basis with the Council.

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

Recent trainings have been conducted on the following topics: **a) Motivational Interviewing:** This training offered providers a practical, common sense approach for supporting clients in making and sustaining healthy behavior changes. **b) Immigration Workshop for HIV Providers:** This training provided skills, tools, and resources for providers to better support people who are undocumented immigrants and refugees within the HIV + community. **c) Crisis Communication and De-escalation:** This training gave an overview of the basics in identifying, preventing, and effectively navigating crises through communication and de-escalation. **d) Group Leadership in Community Work:** This workshop focused on common issues and topics for group leaders, including group guidelines, dealing with challenging participants, common group leader struggles, dealing with conflict, and being devalued as a group leader. **e) Group Work Consultation, Leadership via Case Studies:** This training followed and built upon the Group Leadership in Community Work training and emphasized specific case studies brought by participants in their roles as group leaders. **f) Expansion of San Francisco's Quality Management/Quality Improvement Program:** This training offered technical assistance to align with national priorities, assisted providers to reach the next performance level and sustain a mature management program, and taught Best Practices to assess and update providers' quality management program. **g) Burnout Prevention:** This training explored with participants the causes, consequences, and symptoms of stress and burnout among health and social service staff working with PLWH. **h) Unearthing Implicit Bias, Working Effectively with Diverse Populations:** This training offered practical skills to identify implicit bias in providers' interactions with clients and colleagues, and offered steps to support and repair relationships. **i) Effectively Supporting Safe Inclusive Spaces for LGBTQ Clients and Colleagues:** This workshop presented participants with basic concepts, vocabulary, and skills necessary to provide the best support for intersex, transgender, and other sex/gender non-conforming clients and colleagues. **j) Racism and White Privilege: Navigating difficult personal conversations on racial inequity:** This workshop deepened providers' understanding of the impacts of racism and reviewed how cultural competency and racial identity education can support positive change. **k) Understanding and Interrupting the Cycle of Oppression:** This training introduced providers to the cycle of oppression and ways to dismantle the cycle through examining and understanding stereotypes, prejudice, discrimination, and social power. **l) HIV Nursing Network Conference:** HIV Health Services and the AIDS Education and Training Center provide this training annually for nursing staff in the EMA. Topics covered include HIV 101; Updates on HIV Prevention; Mental Health, Homeless &HIV; Pharmacology Update; Intersection of STDs and PrEP; Managing Chronic Pain; Best Practices in Linkage and Retention; and a panel discussion with consumers across the continuum of care.

- **ORGANIZATIONAL INFORMATION**

A. Grant Administration

1. <u>Program Organization:</u>

a) <u>Administration of Part A Funds:</u>

The grantee agency for Ryan White Part A funds in the San Francisco EMA is the **City and County of San Francisco Department of Public Health (DPH).** Ultimate authority for the administration and expenditure of Part A funds lies with the city's **Mayor, London Breed**, and with the city's **11-member Board of Supervisors**, which acts as both county governing board and city council for San Francisco. This authority is shared with **Grant Colfax, MD for DPH** who now serves as **Director of Public Health** for the City and County of San Francisco (see Organizational Chart in **Attachment 10**). Dr. Colfax previously served as Director of National AIDS Policy under President Obama. The administrative unit overseeing the Part A grant is **HIV Health Services (HHS)**, an organizational unit of the San Francisco Department of Public Health, Primary Care division, overseen by **Roland Pickens,** who serves as **Director of the San Francisco Health Network** for the City and County of San Francisco**.** The **Director of HIV Health Services** is **Bill Blum, LCSW,** who has served in this capacity for **11½ years** and who also serves as **Director of Programs for Primary Care in DPH**. A staff of **9 SFDPH** employees (**8.8 FTE**) - funded with different levels of Part A support - is responsible for directing, coordinating, and monitoring the distribution and expenditure of Part A funds throughout the EMA, working a combined total of **4.89 FTE** with Part A funding. Additionally, a combined total of **1.60 FTE** of staff time is dedicated to Business and Finance Services; **0.33 FTE** to Surveillance/Epidemiology; **0.55 FTE** to Accounting Services; and **0.65 FTE** to the Contracts Administration section (see attached Budget Justification for description of individual staff roles and percentages).

San Francisco HIV Health Services works in close partnership with the **San Francisco HIV Community Planning Council**, a unified prevention and care community planning body with a maximum of **50** seats that meets monthly to oversee the prioritization, allocation, and effective utilization of Ryan White Part A funds. The HIV Community Planning Council represents the merged body of the former SF EMA HIV Health Services Planning Council and the SF HIV Prevention Planning Council. This group - whose initial meeting took place in June 2016 – has purview over the **entire continuum of HIV prevention and care services in our region,** from outreach and testing to linkage and retention, along with all Part A-funded HIV core and support services. At the time of this writing, the Council's work is coordinated by **three Community Co-Chairs**, **Irma Parada, David Gonzalez,** and **Mike Shriver,** and **two Governmental Co-Chairs, Thomas Knoble,** and **Kevin Hutchcroft**. Community Co-Chairs are elected annually for staggered terms and serve two-year terms, and also serve on the Council's **15-member Steering Committee,** which meets on a monthly basis with HIV Health Services staff to coordinate key Council activities and decision-making. Three additional standing committees support the work of the Council: **Council Affairs, Community Engagement**, and **Membership.** Administrative support for the San Francisco HIV Health Services Planning Council is provided through a subcontract to **Shanti Project**, a non-profit service organization**.** The **Director of Planning Council Support, Mark Molnar,** is a former long-term member of the SF HIV Planning Council and previously served as Co-Chair.

The two additional counties that make up the San Francisco EMA have responsibility for administering and distributing Part A funds through their counties' respective health departments. In San Mateo County, Part A and Part B funds are coordinated through the **San Mateo County Health's Director, Louise Rogers**. Responsibility for Part A fund administration lies with **Matt Geltmaker,** who serves as **Director of the San Mateo County STD/HIV Program** and is responsible for oversight of all Ryan White Part A, Part B, MAI, CDC, HIV prevention, and

HOPWA funds as well as subcontractor oversight. In Marin County, Parts A and B funds are administered through **County of Marin Health and Human Services**, whose Director is **Benita McLarin.** She shares responsibility for Part A funds with **Ken Shapiro, Chief Operating Officer.** The **Marin County HIV/AIDS Program** has direct responsibility for Part A fund management and coordination. Direct oversight of Marin Part A funds is provided by **Cicily Emerson, Community Health and Prevention Services Manager** for the County. An EMA-wide Organizational Chart outlining the above relationships is included in **Attachment 10** of this application.

b) Administration by a Contractor or Fiscal Agent:

N/A - The San Francisco EMA does not utilize a contractor or fiscal agent to administer Ryan White Part A funds.

2. Grant Recipient Accountability:

a) Monitoring:

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

For the 2020-2021 Fiscal Year (3/1/20 - 2/28/21), the San Francisco Department of Public Health is utilizing Ryan White Part A funding to support a total of **40** separate programs. These 40 programs are being operated by **16** different community-based organizations (subrecipients), including local non-profits; the University of California San Francisco; and programs administered by the local county health department. Typically, SFDPH Business Office Contract Compliance staff would conduct on-site monitoring visits to **all** of these programs each year and would conduct programmatic and fiscal monitoring visits to all programs in FY 2020 as well. However, this year due to the COVID-19 pandemic and as allowed by HRSA, no in-person site visits have been conducted this year. However, **remote desk audits** to review performance data, evaluate program performance objectives, and assess level of contract deliverables are still being conducted. **Monitoring Reports** have been written to evaluate those performance indicators in these and other areas which can be verified remotely. San Francisco's **Citywide Nonprofit Monitoring and Capacity-Building Program,** which conducts in-depth fiscal and

compliance monitoring of all nonprofit contractors funded by two or more City departments, were also put on hold this fiscal year due to the pandemic as well

For both the past and current Ryan White Part A fiscal year, there were no major monitoring findings that required corrective actions. In the past, the three most commonly identified items identified in the program and fiscal monitoring process have included: a) guidance for improving client satisfaction survey distribution and returns; b) helping providers appropriately utilize client data to demonstrate compliance with QI related performance objectives; and c) working with providers who may have difficulty in achieving deliverable targets for units of service or clients being served. Often, these issues often stem from new staff at the provider level who require more detailed training and guidance. The HHS Assistant Director convenes a meeting with the providers and appropriate HHS staff to administer the TA to develop the skills in these and other area of needed improvement. Occasionally, program and client changes over time may require that HHS work with a provider to develop alternative performance objectives, or perhaps lower the threshold of their target goals. Discussions and negotiations on adjusting target goals, units of service, and/or unduplicated clients are very rare, but they do occur, especially when new additional modalities of service are introduced into an existing program.

If other specific programmatic concerns are identified at a Part A-funded agency, information is **immediately** sought from staff of the contracted agency. Contractors may be asked to explain why deliverables are low, why a high staff turnover rate exists, or what actions have been taken to resolve a specific consumer grievance. A recommendation to address the issue is then collaboratively developed, usually accompanied by specific deliverables and target dates for redressing the issue, such as developing a modified work plan within 30 days or completing a process of staff training within 60 days. Providers are required to formally report on their progress in addressing such recommendations in a written action plan to be submitted within an established deadline, as well as during the following year's monitoring process. Grantee staff follow up on areas of concern after reports have been received. TA is provided for contracting agencies in areas such as staff training and orientation, adoption and replication of best practices, and/or collaboration. Agencies with ongoing problems are referred to the Fiscal Compliance Unit's Contract Oversight Committee which works to develop a corrective action plan for the agency to maintain ongoing funding and good standing. As noted above, there are currently no RWPA funded programs involved in a Departmental Corrective Action Plan.

ii. Compliance with Single Audit Requirement: All HHS Part A-funded Contractors (100%) are required to provide an Audit report for the last fiscal year in compliance with Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR part 75). All 16 contractors have complied with this requirement.

iii. Improper Findings and Actions: There were no problems reported from subrecipient single audit or program-specific audit reports.

b) Third Party Reimbursement:

i. Ensuring Monitoring of Third Party Reimbursement: The San Francisco Department of Health is committed to maximizing third party reimbursement across the EMA to ensure that Part A funds are always used as the funding source of last resort. This is not only to comply with Ryan White Act requirements, but because the fiscal crises local and state systems are facing in the wake of the COVID-19 pandemic compels the region to further maximize its reimbursement streams. To this end, all three SF EMA counties have taken steps to ensure that all available reimbursement sources in the region are fully utilized, including: a) continually educating providers on the availability of third-party reimbursement streams; b) expanding the capacity of local organizations to bill for services, including assistance in obtaining licensure and certification and developing electronic billing systems; c) training agencies to conduct eligibility screening and enrollment for clients, including training to help clients manage their own benefits and eligibility; and d) providing regularly updated information on emerging developments in reimbursements, rates, and requirements. The EMA has also taken steps to verify during the site visits and monitoring process that Part A contractors are fully maximizing reimbursement streams, and that rigorous protocols are followed to ensure that Part A funds are only used **after** all other funding sources have been exhausted. The generalized formula used by HIV service providers to determine client benefits eligibility is to lead each client through an **intake/registration procedure** in which standardized questions are asked pertaining to factors such as HIV status, residence, age, employment status, income, insurance, health status, and other factors to determine if third party insurance and Medicaid coverage are an option. Providers are then required to assist clients in obtaining all benefits for which they may be eligible, including referring them to agencies that provide benefits assistance. All HIV Requests for Proposals (RFPs) and contracts contain highlighted language stressing that Ryan White funds will be used **only** for services that are not reimbursed through any other source of revenue and new contracting agencies receive training to familiarize them with other appropriate payment sources for specific services and programs.

ii. Documenting Client Screening for Eligibility and to Ensure that Ryan White is the Payer of Last Resort: Service providers are monitored to ensure compliance with Ryan White Program policy and guidelines pertinent to third-party reimbursement. Contracted service providers must provide a description of their screening practices for determining client eligibility for receipt of services, as well as a roster of all third-party payer sources they utilize. Local health department policies in all three EMA counties mandate that if a client is found eligible for coverage from a payer source other than Ryan White - such as Medicaid, Medicare, or private insurance – then that source **must** be billed before seeking reimbursement from Ryan White. **In these cases, payment received is considered as payment in full, and balance-billing to Ryan White is not permitted.** Technical assistance is provided where needed to ensure that agencies modify and improve their eligibility standards or attain greater competency in maximizing third-party billing procedures.

iii. Tracking Program Income and Rebates: HIV Health Services and the SFDPH Office of Contract Development and Technical Assistance require all agencies funded through Ryan

White Programs to provide a complete budget summary of all program funding sources and incomes as well as program expenditures. All programs must demonstrate that their total program funding equals total program expenditures for each fiscal year in the budget.

c) Fiscal Oversight:

i. Process Used by Program and Fiscal Staff to Coordinate Activities and Ensure Adequate Reporting, Tracking, and Reconciliation of Program Expenditures: The staff of the City and County of San Francisco Controller's Office monitors federal funds awarded to nonprofit organizations. For nonprofit organizations receiving $750,000 or more in federal funds, the Controller's Office reviews audited financial statements and single audit reports for compliance with the Single Audit Act and OMB Circular A-133. In Fiscal Year (FY) 2020, the Controller reviewed single audit reports for a total of **31** SFDPH HIV Health Services-funded organizations including **all 16** Part A-funded community based organizations. The Controller found that all of these organizations had appropriate and timely processes and practices in place.

San Francisco EMA programmatic monitoring, contract development, oversight, compliance, and monitoring functions are overseen by the Department of Public Health's new **Community Programs Business Office**, created in an effort to consolidate services and maximize efficiencies. The centralized Business Office is staffed by **17** program managers from all SFDPH systems of care and consists of two sections: 1) the **Business Office of Contracts Compliance Unit (BOCC)** and 2) the **Contract Development and Technical Assistance Unit (CDTA).** The Contract Compliance Unit provides annual program review; conducts controller's fiscal and compliance review for SFDPH contracts; performs fiscal audits; oversees provider certification and licensing (PPN and Civil Service); performs site certification reviews; and, if indicated, oversees corrective action plan development and oversight. The Unit also ensures that contracted Part A programs: a) are effectively managed; b) meet their contract deliverables; c) serve their target populations in professional and culturally competent ways, including adhering to published standards of care; and d) maximize external resources to ensure that Ryan White dollars are always used as the funding source of last resort. Additionally, all EMA member counties employ strategies to clarify provider responsibilities, track contractor performance, monitor service quality, and ensure maximum reimbursements. All BOCC and CDTA staff have been trained by HHS, which maintains regular and ongoing communication to inform them of all HRSA/HAB requirements and updates. HHS staff participate in all site visits with BOCC and review monitoring reports before they are finalized.

Responsibility for fiscal monitoring and oversight of the Ryan White Part A grant lies with a **six-member team** at the San Francisco Department of Public Health Grants, Accounts Payable and Procurement unit. The team is supervised by the **Deputy Financial Officer, Anne Okubo,** who supervises and directs staff in the fiscal grants unit and payables section and supervises and directs all fiscal requirements for Federal, State and private grants for the Population Health and Prevention Division (PHP). This includes setting up grant accounting for new grants; reviewing and monitoring grant revenues, expenditures, and positions; analyzing revenues and expenditures; preparing fiscal reports; reconciling grant accounts; and closing out completed grants. Staff of the Office review all Ryan White contractor and subcontractor programmatic

budgets and reconcile expenditures in accordance with standard accounting practices. They also approve each grant fund encumbrance in accordance with availability of grant funding.

ii. Process to Separately Track Formula, Supplemental, MAI, and Carry Over Funds, Including Data Systems Utilized: HIV Health Services maintains a system for tracking all funding by funding source, including formula and supplemental funds. Additional tracking systems are used by SFDPH Contracts Unit and Fiscal Unit staff assigned to work with HHS. A **bi-weekly budget meeting** attended by staff from all four units ensures accurate tracking across programs. **For FY 2019, all Part A funds were put into contracts; therefore, the EMA had no unobligated dollars.** In FY 2018, HIV Health Services also conducted both a **service category** and a **program level analysis** based on past and current fiscal performance to assign and track formula and supplemental funds. Formula dollars were prioritized to fund core services and supplemental dollars were targeted to fund support services.

iii. Receipt and Payment of Vouchers / Invoices from Subcontractors: HHS contractors submit monthly invoices to the SFDPH Business Office Fiscal Invoice Section for review and submission for reimbursement. The Fiscal Invoice staff has **two** invoice analysts who review invoices for accuracy and performance and - upon approval - forward to the Accounts Payable Contracts and Reconciliation section for payment. The invoice analysts review invoice line items to control for over-invoicing and also ensure that submitted invoices match final or modified contract budget details. The invoice analysts also check the level of contract deliverables (both contract units and unduplicated client targets) quarterly and calculate if the program performance is within the **85%** range required at these "milestone" reviews. Programs not performing within 85% of "milestone" marks have their invoices held without payment while their invoices are sent to the CDTA Program Manager and the HHS Administrator for review and consultation. The program is then contacted, and the source of the underperformance is discussed. If deemed necessary, the program is requested to submit a written explanation and a course of action to correct the issue and work toward getting caught up on contract deliverables. Once approved by the HHS Administrator or Director, the invoice analysts then move forward with processing for payment. Once the AIDS Office Fiscal Analysts review and process for payment, the Accounts Payable – Contracts and Reconciliation section performs their final review and forwards to the Controller's Office for payment. Payments are either sent by check via U.S. Mail or deposited electronically into the contractors' bank account by SF's Auto Clearinghouse Payment Processing for those contractors who establish this mechanism with the City. Payments are processed once weekly.

B. Maintenance of Effort

Please see Maintenance of Effort report in **Attachment 11.**

ENDNOTES

[1] US Census Bureau, *California QuickFacts*, Marin, San Francisco, & San Mateo Counties, Accessed September 1, 2020.
[2] California Department of Public Health, Center for Infectious Diseases, Office of AIDS, *California HIV Surveillance Report – 2018*, Sacramento, CA, February 27, 2020 and US Centers for Disease Control and Prevention, "Diagnosis of HIV Infection and AIDS in the United States and Dependent Areas, 2018, *HIV Surveillance Report*, Vol. 31, May 27, 2020.
[3] Ibid.
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[5] New York City Department of Health and Mental Hygiene, *HIV Surveillance Mid-Year Report, 2019* New York, NY, September 30, 2019.
[6] Estimate of total PLWH living at 300% of poverty or below based on 98,8% rate of PLWH receiving Part A services living at or below 300% of poverty in FY 2017-18 (n=6,924) plus conservatively estimated 27.6% rate of 300% at or below FPL for all other PLWH (2,157 of 7,816 remaining PLWH)(poverty same as overall region-wide rate).
[7] Calculation based on annual projected average cost of $35,000 per person for HIV treatment and medical care x 14,960 total PLWH in EMA x .607, representing estimated percentage of all persons with HIV living in poverty.
[8] Brookings Institution, *City and metropolitan income inequality data reveal ups and downs through 2016*, February 5, 2018, https://www.brookings.edu/research/city-and-metropolitan-income-inequality-data-reveal-ups-and-downs-through-2016/
[9] Public Policy Institute of California, *Income inequality in California*, Sacramento, CA, January 2020.
[10] St. Lawrence, J. & Brasfield, T., "HIV high risk behavior among homeless adults," *AIDS Education Prevention*, 7(1):22-31, 1995.
[11] National Low Income Housing Coalition, *Out of Reach 2020,* Washington, DC, 2020, https://reports.nlihc.org/oor
[12] US Department of Housing and Urban Development (HUD), FY 2021 Fair Market Rent Documentation System, Accessed October 2020.
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[18] State of California Department of Health Services, STD Control Branch, "Primary and Secondary Syphilis, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2014-2018 Provisional Data," Sacramento, CA, July 10, 2019.
[19] State of California Department of Health Services, STD Control Branch, "Gonorrhea, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2014-2018 Provisional Data," Sacramento, CA, July 10, 2019.
[20] State of California Department of Health Services, STD Control Branch, "Chlamydia, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2014-2018 Provisional Data," Sacramento, CA, July 10, 2019.
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[23] The San Francisco Injury Center, Op. Cit.
[24] Dilley, D. & Loeb, L., Op. Cit.
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[27] California Department of Public Health, Drug-induced deaths ranked by three-year average age-adjusted death rate, California Counties, 2006-2008, *County Health Status Profiles 2010*, Sacramento, CA, July 2010.
[28] The San Francisco Injury Center, San Francisco Department of Public Health, *Profile of Injury in San Francisco 2004*, San Francisco, CA, 2002, December 2004.
[29] Heredia, C., "Dance of death, first of three parts: Crystal meth fuels HIV," *San Francisco Chronicle*, San Francisco, CA, May 4, 2003.
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CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure of Lobbying Activities,'' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION	San Francisco Department of Public Health
* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
Prefix:	Ms.
* First Name:	Anna
Middle Name:	
* Last Name:	Robert
Suffix:	
* Title:	Director of Primary Care
* SIGNATURE:	Completed on submission to Grants.gov
* DATE:	Completed on submission to Grants.gov

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** Budget Narrative.pdf

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

RWHAP PART A BUDGET SUMMARY
APPLICANT: San Francisco EMA
FISCAL YEAR: 21-22

	Part A			Minority AIDS Initiative (MAI)			Total
Object Class Categories	**Administration**	**CQM**	**HIV Services**	**Administration**	**CQM**	**HIV Services**	
a. Personnel	$ 456,124	$ 122,635	$ -	$ 58,485		$ -	**$ 637,244**
b. Fringe Benefits	$ 191,572	$ 51,507	$ -	$ 24,564		$ -	**$ 267,642**
c. Travel	$ 1,800	$ -	$ -	$ -		$ -	**$ 1,800**
d. Equipment	$ -	$ -	$ -	$ -		$ -	**$ -**
e. Supplies	$ 7,385	$ 1,000	$ -	$ -		$ -	**$ 8,385**
f. Contractual	$ 717,737	$ 120,317	$ 13,144,902	$ -		$ 747,507	**$ 14,730,463**
g. Other	$ 22,000	$ 60,000	$ -	$ -		$ -	**$ 82,000**
Direct Charges	**$ 1,396,618**	**$ 355,459**	**$ 13,144,902**	**$ 83,049**	**$ -**	**$ 747,507**	**$ 15,727,535**
Indirect Charges		**$ 12,032**		**$ -**	**$ -**		**$ 12,032**
TOTALS	**$ 1,396,618**	**$ 367,490**	**$ 13,144,902**	**$ 83,049**	**$ -**	**$ 747,507**	**$ 15,739,566**
Program Income							**$ -**

2021 Funding Ceiling:

Part A Funding	$14,909,010
MAI Funding	$830,556
Total:	**$15,739,566**

Administrative Budget 10%:

Part A Within Limit **MAI** Within Limit

CQM Budget 5%:

Part A Within Limit **MAI** Within Limit

PART A ADMINISTRATIVE BUDGET
APPLICANT: San Francisco EMA
FISCAL YEAR: 21-22

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
$ 170,214	0.20	Michelle Long, Director of CDTA	Charged with primary oversight of contract development, modifications, and renewals of all Ryan White Part A grants. .80 FTE GF	$ 34,043
$ 147,049	0.50	TBD, Director of Contract Compliance	Charged with oversight of contractor performance and compliance for Ryan White Part A grants. .50 GF	$ 73,524
$ 147,049	0.40	Bill Blum, Director of HIV Health Services	Charged with primary oversight for the administration of services and day to day operations of HIV Health Services and the Ryan White Part A grant. .60 FTE GF	$ 58,820
$ 117,537	0.75	Francine Austin, CDTA Program Manager	Provides programmatic oversight and monitoring of case management and integrated services program. .25 FTE GF	$ 88,153
$ 117,537	0.15	Marsha Herring, Compliance Program Manager.	Provides oversight of contractor performance and compliance for Ryan White Part A grants. .50 FTE RWPA MAI & .35 GF	$ 17,631
$ 136,658	0.20	Dean Goodwin, Assistant Director of HIV Health Services	Dean Goodwin is responsible for the overall planning, evaluation and quality management for HHS as the grantee for the San Francisco HIV System of Care in coordination with our Ryan White mandated HIV Health Services Planning Council. .60 FTE CQM & .35 FTE GF	$ 27,332
$ 91,674	0.33	TBD, Epidemologist	Principal duties include data quality, satistical analysis and interpretation of findings, manuscript preparation and dissemination of findings. .67 FTE GF	$ 30,252
$ 136,658	0.30	Irene Carmona, Contracts Manager	Supervises contract management staff and ensures contract development compliance. .70 FTE GF	$ 40,998
$ 118,046	0.15	Nora Macias, Contract Analyst	Processes contracts and assures compliance with local, state and federal regulations. .85 FTE GF	$ 17,707
$ 93,864	0.20	Jeannette Zhong, Sr Accountant	Responsible for supervision and management of grant accountant activities. Certified grant revenues and expenditures for annual appropriation. .80 FTE GF	$ 18,773
$ 65,716	0.15	Daniela Georgieva, Accountant	This position is responsible for establishing appropriate classification structure within the general ledger account for grants and ensures claims/costs are in compliance with the appropriate regulations. This position is responsible for grant accounts payable activities and reconciles with expenditure reports and claims. .50 FTE GF	$ 9,857
$ 93,864	0.20	Stacey Hom, Accountant	This position is responsible for establishing appropriate classification structure within the general ledger account for grants and ensures claims/costs are in compliance with the appropriate regulations. This position is responsible for grant accounts payable activities and reconciles with expenditure reports and claims. .80 FTE GF	$ 18,773
$ 101,309	0.20	William Gaitan, Contract Analyst	Processes contracts and assures compliance with local, state and federal regulations. .80 FTE GF	$ 20,262
				$ -
			Personnel Total	**$ 456,124**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
16.63%	Insurance(Medical/Life)	$ 75,853
7.65%	Social Security	$ 34,893
12.00%	Retirement	$ 54,735
1.50%	Workers Compensation	$ 6,842
4.22%	Others (Disability, Unemployment, Medicare, Life Insurance, and Supp. Ret.)	$ 19,248
		$ -
	Fringe Benefit Total	**$ 191,572**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
		various staff	To purchase monthly bus passes to travel to sites/meetings ($75 bus pass/mo. x 2 staff x 12 mo)	$ 1,800
			Local Travel Sub-Total	**$ 1,800**

Long Distance

PART A ADMINISTRATIVE BUDGET
APPLICANT: San Francisco EMA
FISCAL YEAR: 21-22

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
		Long Distance Travel Sub-Total	$ -
		Travel Total	$ 1,800

Equipment
[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	$ -

Supplies
[Supplies is defined as property with a unit cost under $5,000. ***Note:*** *Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
General Office Supplies, Pen, pencil, paper, binders, folder, presentation materials	164.99/mos X 3.73 FTE X 12 months	$ 7,385
	Supplies Total	$ 7,385

Contractual

List of Contract	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	Amount
Robert Whirry		Grant Writing/Consulting	$ 66,697
Shanti/ALRP		Planning Council Support + HIV Consumer Advocacy	$ 435,592
HR360		HHS Progam/Fiscal Admin	$ 215,448
		Contracts Total	$ 717,737

Other
[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
Rent	1.966/sq ft x 250 x 3.73 fte x 12 mos	$ 22,000
	Other Costs Total	$ 22,000

Total Direct Cost

	$ 1,396,618

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *[Insert rate below]*	Insert Base	Total [Insert Indirect]
			$ -

Part A Administrative Total

	$ 1,396,618

PART A PLANNING COUNCIL BUDGET
APPLICANT: Shanti Planning Council
FISCAL YEAR: 21-22

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
$ 99,500	0.75	Mark Molnar, Program Director	Responsible for the direction and executive oversight of all HHSPC Support tasks, functions as an alternative liaison between the HHSPC and stakeholders, government entitites, and community bodies	$ 74,625
$ 55,000	1.00	D. Jordan, Program Manager	Admin oversight & implementation of all trainings & orientations; supervises annual needs assessment & community outreach listening activities (COLA	$ 55,000
$ 55,000	0.50	Ali Cone, Program Manager	Maintaining compliance with CA State protocols & HCPC by-laws, policies, procedures; tracks membership attendance & demographics; liason with Mayor's Office.	$ 27,500
$ 54,000	0.25	J Williams, Program Manager	Grantee assessment and other duties as needed.	$ 13,500
$ 45,000	0.85	M. Clark Program Coordinator	Notetaking & minutes at Council meetings; maintenance of recordings & website; coordinates requests for information; facilitates focus group meetings.	$ 38,250
$ 43,000	0.44	Liz Strum, Program Assistant	Responsible for notetaking & minutes at Council meetings; other duties as needed	$ 18,848
				$ -
			Personnel Total	**$ 227,723**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
7.65%	Social Security	$ 17,420
7.35%	Medical	$ 16,738
1.50%	Dental	$ 3,416
1.00%	Unemployment Insurance	$ 2,278
		$ -
	Fringe Benefit Total	**$ 39,851**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
			Local Travel Sub-Total	**$ -**

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
		Long Distance Travel Sub-Total	**$ -**
		Travel Total	**$ -**

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	**$ -**

Supplies

*[Supplies is defined as property with a unit cost under $5,000. **Note**: Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount

Pens, Paper, folder, etc	Costs for office supplies, proportionate to program utilization (Total agency $25,860/54.1 FTE x 3.79 FTE = 1,812)	$ 1,812
	Supplies Total	**$ 1,812**

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	Amount
		Contracts Total	**$ -**

Other

[List all costs that do not fit into any other category]

List of Other		Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
Rent		Montly rent expense for the proportion of office space utilized by (Anuual Rent 256,885.20/29.195 FTE @ Polk St location	$ 33,348
Phone		Costs for phone and internet usage, proportionate to program utilization (Total agency $22,310/total FTE 54.1 X2 FTE = 825	$ 825
Printing & Reproduction		Print runs for heavy print jobs for special events in which binders are required (3 orientation trainings, 1 summit). $318 x 4 events	$ 1,272
Insurance		Proportionate share of cost for general liability insurance required for operations. (Total agency $31,347/total 54.1 FTE x 3.79 FTE = 2,196)	$ 2,196
Rental of Equipment		Proportionate share of cost to operate leased copiers for printing and reproduction of materials and reports (Total agency $9,120/54.1 FTE x 3.79 FTE = 2,040)	$ 2,040
		Other Costs Total	**$ 39,681**

Total Direct Cost

	$ 309,067

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]
Fixed	**9%**	**$309,067**	**27,810**

Part A Planning Council Total

	$ 336,877

PART A PLANNING COUNCIL BUDGET
APPLICANT: AIDS Legal Referral Panel
FISCAL YEAR: 21-22

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
$ 63,292	1.00	Stephen Spano, HCAP Attorney	Conduct outreach activities, provide advocacy, and offer mediation services; provide technical assistance to providers; prepare quarterly reports on consumer issues and their resolution	$ 63,292
$ 100,000	0.02	Bill Hirch, ED	Supervise HCAP Attorney; oversee agency collaborations and attorney-client relations; conduct program evaluation activities; oversee compliance with contract objectives and requirements including ARIES data implementation. Conduct Client Services meetings at which client services staff discuss trends, cases and client feedback.	$ 2,000
				$ -
				$ -
				$ -
			Personnel Total	**$ 65,292**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
7.65%	Social Security	$ 4,995
12.98%	Medical	$ 8,475
0.50%	Dental	$ 326
0.48%	Unemployment Insurance	$ 313
0.39%	Worker Compensation Insurance	$ 255
		$ -
	Fringe Benefit Total	**$ 14,364**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
			Local Travel Sub-Total	**$ -**

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
		Long Distance Travel Sub-Total	**$ -**
		Travel Total	**$ -**

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	**$ -**

Supplies

*[Supplies is defined as property with a unit cost under $5,000. **Note**: Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
Office Supplies	5.5% of supplies, allocated by shared cost based on FTE ($26,636 X 5.5%)	$ 1,465
Postage	5.5% of postage, allocated by shared cost based on FTE ($10,100 X 5.5%)	$ 556
	Supplies Total	**$ 2,021**

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	Amount
IT Consultants		IT and database consultation costs, allocated by shared cost based on FTE ($16,332 X 5.5%)	$ 898
		Contracts Total	**$ 898**

Other

[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
Rent	5.5% of office space, allocated by shared cost based on FTE; reduced by $944 to fit within the overall limit for this budget (($101,120 X 5.5%)-944)	$ 4,638
Telephone	5.5% of phone, allocated by shared cost based on FTE ($15,000 X 5.5%)	$ 825
General Liability Insurance	5.5% of insurance premium, allocated by shared cost based on FTE ($6,894 X 5.5%)	$ 379
Professional Liability Insurance	$1, 718 per attorney FTE	$ 1,718
Equipment Rental/Repair	5.5% of equipment rental and repair, allocated by shared cost based on FTE ($7,797 X 5.5%)	$ 429
	Other Costs Total	**$ 7,989**

Total Direct Cost

	$ 90,564

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]
Fixed	9%	Bookkeeper salary and benefits, audit costs, pa roll processing costs, financial consultant costs	**8,151**

Part A Planning Council Total

	$ 98,715

PART A CLINICAL QUALITY MANAGEMENT BUDGET
APPLICANT: San Francisco EMA
FISCAL YEAR: 21-22

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
$ 117,537	0.15	Joseph Cecere, Program Manager	Administrator of the HIV Health Services client services database (ARIES) is responsible for the staffing of the ARIES users trainings, managing the coverage for the ARIES helpdesk line and overall implementation and planning for communications, updates, and oversight of this system.	$ 17,631
$ 105,004	1.00	Kevin Hutchcrofit, Program Manager & ADAP Coordinator	Conducts QM training program providing and many trainings annually for all our funded providers.	$ 105,004
				$ -
				$ -
			Personnel Total	**$ 122,635**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
16.63%	Insurance(Medical/Life)	$ 20,394
7.65%	Social Security	$ 9,382
12.00%	Retirement	$ 14,716
1.50%	Workers Compensation	$ 1,840
4.22%	Others (Disability, Unemployment, Medicare, Life Insurance, and Supp. Ret.)	$ 5,175
	Fringe Benefit Total	**$ 51,507**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
			Local Travel Sub-Total	**$ -**

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	Amount
		Long Distance Travel Sub-Total	**$ -**
		Travel Total	**$ -**

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
	Equipment Total	**$ -**

Supplies

*[Supplies is defined as property with a unit cost under $5,000. **Note**: Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*

List of Supplies	Budget Impact Justification *[Description of need to carry out the program's objectives/goals]*	Amount
Office Supplies	**Office Supplies and postal services.**	$ 500
Building Repar/Maintanence	**Keys, lock smith services and etc.**	$ 500
	Supplies Total	**$ 1,000**

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	Amount
HR360		Assisting with QI analysis, data collection, programming, etc.	$ 33,614
HR360		Trainers: Providing QM oriented training for HHS providers	$ 86,703
		Contracts Total	**$ 120,317**

Other

[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
Client Incentive Vouchers	Famer's Market or other vouches ($5 x 2000)	$ 10,000
Client Incentive Vouchers	Subway/ Burger King ($5 x 10000)	$ 50,000
	Other Costs Total	**$ 60,000**

Total Direct Cost

	$ 355,459

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]
fixed	**10%**	hr360: an allocation of adminstrative and support staff salary and related fringe benefits and general overhead expenses related to the contract	**$ 12,032**

Part A Clinical Quality Management Total

	$ 367,490

PART A HIV SERVICES BUDGET
APPLICANT: San Francisco EMA
FISCAL YEAR: 21-22

Personnel

Salary *[Insert total annual salary]*	**FTE** *[Insert as decimal]*	**Name, Position** *[Insert name, position title]*	**Budget Impact Justification** *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	**Amount**
				$ -
				$ -
				$ -
				$ -
				$ -
			Personnel Total	$ -

Fringe Benefits

Percentage *[Insert as %]*	**Components** *[List components that comprise the fringe benefit rate]*	**Amount**
		$ -
		$ -
	Fringe Benefit Total	$ -

Travel

Local

Mileage Rate	**Number of Miles**	**Name, Position of Traveler(s)**	**Travel Expenses/Budget Impact Justification** *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	**Amount**
			Local Travel Sub-Total	$ -

Long Distance

Type of Travel	**Name, Position of Traveler(s)**	**Travel Expenses/Budget Impact Justification** *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	**Amount**
		Long Distance Travel Sub-Total	$ -
		Travel Total	$ -

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	**Budget Impact Justification** *[Description of need to carry out the program's objectives/goals]*	**Amount**
	Equipment Total	$ -

Supplies

[Supplies is defined as property with a unit cost under $5,000. ***Note:*** *Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*

List of Supplies	**Budget Impact Justification** *[Description of need to carry out the program's objectives/goals]*	**Amount**
	Supplies Total	$ -

Contractual			
List of Contracts	**Deliverables**	**Budget Impact Justification** *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	**Amount**
Outpatient/Ambulatory Health Services		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 549,788
Oral Health Care		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 857,829
EIS		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 134,500
Health Insurance Assistance		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 50,560
Home Health Care		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 284,545
Hospice		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 851,008
Mental Health		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 1,570,461
Substance Abuse Services (outpatient)		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 197,494
Medical Case Management		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 3,197,076
Non-Medical Case Management		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 2,310,097
Emergency Financial Assistance		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 1,194,964
Food		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 247,018
Housing		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 570,290
Medical Transportation		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 22,753
Outreach		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 287,217

Psycho-Social Support		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 513,906
Other Professional Services		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 305,396
		Contracts Total	**$ 13,144,902**

Other

[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
	Other Costs Total	**$ -**

Total Direct Cost

	$ 13,144,902

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]

Part A HIV Services Total

	$ 13,144,902

MAI ADMINISTRATIVE BUDGET
APPLICANT: San Francisco EMA
FISCAL YEAR: 21-22

Personnel

Salary *[Insert total annual salary]*	FTE *[Insert as decimal]*	Name, Position *[Insert name, position title]*	Budget Impact Justification *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	Amount
$ 117,537	0.50	Marsha Herring, Compliance Program Manager.	Provides oversight of contractor performance and compliance for Ryan White Part A grants. .15 RWPA & .37 GF	$ 58,485
			Personnel Total	**$ 58,485**

Fringe Benefits

Percentage *[Insert as %]*	Components *[List components that comprise the fringe benefit rate]*	Amount
18.08%	Insurance(Medical/Life)	$ 10,574
6.20%	Social Security	$ 3,626
12.00%	Retirement	$ 7,018
1.50%	Workers Compensation	$ 877
4.22%	Others (Disability, Unemployment, Medicare, Life Insurance, and Supp. Ret.)	$ 2,468
	Fringe Benefit Total	**$ 24,564**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount
			Local Travel Sub-Total	$ -

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount
		Long Distance Travel Sub-Total	$ -
		Travel Total	$ -

Equipment

List of Equipment	Budget Impact Justification	Amount
	Equipment Total	$ -

Supplies

List of Supplies	Budget Impact Justification	Amount
	Supplies Total	$ -

Contractual

List of Contracts	Deliverables	Budget Impact Justification	Amount
		Contracts Total	$ -

Other

List of Other	Budget Impact Justification	Amount
	Other Costs Total	$ -

Total Direct Cost

	$ 83,049

Indirect Cost

Type of Indirect	Rate	Insert Base	Total

MAI Administrative Total

	$ 83,049

MAI HIV SERVICES BUDGET
APPLICANT: San Francisco EMA
FISCAL YEAR: 21-22

Personnel

Salary *[Insert total annual salary]*	**FTE** *[Insert as decimal]*	**Name, Position** *[Insert name, position title]*	**Budget Impact Justification** *[Description of duties, impact on program goals and outcomes, payment source for balance of FTE]*	**Amount**
				$ -
			Personnel Total	$ -

Fringe Benefits

Percentage *[Insert as %]*	**Components** *[List components that comprise the fringe benefit rate]*	**Amount**
		$ -
		$ -
	Fringe Benefit Total	$ -

Travel

Local

Mileage Rate	**Number of Miles**	**Name, Position of Traveler(s)**	**Travel Expenses/Budget Impact Justification** *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	**Amount**
			Local Travel Sub-Total	$ -

Long Distance

Type of Travel	**Name, Position of Traveler(s)**	**Travel Expenses/Budget Impact Justification** *[Lodging, parking, per diem, etc., and the impact of the travel on program objectives/goals]*	**Amount**
		Long Distance Travel Sub-Total	$ -
		Travel Total	$ -

Equipment

[Equipment is defined as a unit cost of $5,000 or more and a useful life of 1 or more years. (If your agency uses a different definition, please defer to your agency's definition.)]

List of Equipment	**Budget Impact Justification** *[Description of need to carry out the program's objectives/goals]*	**Amount**
	Equipment Total	$ -

Supplies

*[Supplies is defined as property with a unit cost under $5,000. **Note:** Items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 threshold.]*

List of Supplies	**Budget Impact Justification** *[Description of need to carry out the program's objectives/goals]*	**Amount**
	Supplies Total	$ -

Contractual

List of Contracts	Deliverables	Budget Impact Justification *[Description of how the contract impacts the program's objectives/goals and how the costs were estimated]*	Amount
Outpatient/Ambulatory Health Services		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 451,648
Medical Case Management		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 207,890
Substance Abuse Services (Outpatient)		All items are currently part of the broad System of HIV Care and align with the goals and priorities of the local HIV Planning Council, costs were estimated based on last year's expenditures and actual service deliverabels by each service category.	$ 87,969
		Contracts Total	**$ 747,507**

Other

[List all costs that do not fit into any other category]

List of Other	Budget Impact Justification *[Impact on the program's objectives/goals]*	Amount
	Other Costs Total	**$ -**

Total Direct Cost

	$ 747,507

Indirect Cost

Type of Indirect Cost *[Select from dropdown list]*	Rate *(Insert rate below)*	Insert Base	Total [Insert Indirect]

MAI HIV Services Total

	$ 747,507

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 02/28/2022

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. FY 2021 Ryan White Part A - Administrative (Part A and MAI)	93.914	$	$	$ 1,479,667.00	$	$ 1,479,667.00
2. FY 2021 Ryan White Part A - CQM (Part A and MAI)	93.914			367,490.00		367,490.00
3. FY 2021 Ryan White Part A - HIV Services (Part A and MAI)	93.914			13,892,409.00		13,892,409.00
4.						
5. Totals		$	$	$ 15,739,566.00	$	$ 15,739,566.00

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SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) FY 2021 Ryan White Part A - Administrative (Part A and MAI)	(2) FY 2021 Ryan White Part A - CQM (Part A and MAI)	(3) FY 2021 Ryan White Part A - HIV Services (Part A and MAI)	(4)	(5)
a. Personnel	$ 514,609.00	$ 122,635.00	$	$	$ 637,244.00
b. Fringe Benefits	216,136.00	51,506.00			267,642.00
c. Travel	1,800.00				1,800.00
d. Equipment					
e. Supplies	7,385.00	1,000.00			8,385.00
f. Contractual	717,737.00	120,317.00	13,892,409.00		14,730,463.00
g. Construction					
h. Other	22,000.00	60,000.00			82,000.00
i. Total Direct Charges (sum of 6a-6h)	1,479,667.00	355,458.00	13,892,409.00		$ 15,727,534.00
j. Indirect Charges		12,032.00			$ 12,032.00
k. TOTALS (sum of 6i and 6j)	$ 1,479,667.00	$ 367,490.00	$ 13,892,409.00	$	$ 15,739,566.00
7. Program Income	$	$	$	$	$

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. FY 2021 Ryan White Part A - Administrative (Part A and MAI)	$	$	$	$
9. FY 2021 Ryan White Part A - CQM (Part A and MAI)				
10. FY 2021 Ryan White Part A - HIV Services (Part A and MAI)				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 15,739,566.00	$ 3,934,891.50	$ 3,934,891.50	$ 3,934,891.50	$ 3,934,891.50
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 15,739,566.00	$ 3,934,891.50	$ 3,934,891.50	$ 3,934,891.50	$ 3,934,891.50

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. FY 2021 Ryan White Part A - Administrative (Part A and MAI)	$	$	$	$
17. FY 2021 Ryan White Part A - CQM (Part A and MAI)				
18. FY 2021 Ryan White Part A - HIV Services (Part A and MAI)				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: 15,727,534

22. Indirect Charges: 12,032

23. Remarks:

OMB Number: 4040-0010
Expiration Date: 12/31/2022

Key Contacts Form

*** Applicant Organization Name:**

San Francisco Department of Public Health

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Project Administrator

Prefix:	Mr.
* First Name:	Dean
Middle Name:	
* Last Name:	Goodwin
Suffix:	
Title:	Assistant Director of HIV Health Services

Organizational Affiliation:

* Street1:	25 Van Ness Avenue, 8th Floor
Street2:	
* City:	San Francisco
County:	San Francisco
* State:	CA: California
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	94102-6012
* Telephone Number:	628-206-7675
Fax:	
* Email:	Dean.Goodwin@sfdph.org