File No. 140926 Committee Item No. 2
Board Item No. 21

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget & Finance Committee **Date** September 24, 2014

Board of Supervisors Meeting **Date** September 30, 2014

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Completed by: Linda Wong **Date** September 19, 2014
Completed by: L.W. **Date** September 24, 2014

[Apply for Grant - Ryan White Act HIV/AIDS Emergency Relief - $36,118,233]

Resolution authorizing the Department of Public Health to submit an application to continue to receive funding for the Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A) Grant from the Health Resources Services Administration, requesting $36,118,233 in HIV emergency relief program funding for the San Francisco Eligible Metropolitan Area for the period of March 1, 2015, through February 28, 2016.

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

WHEREAS, San Francisco Department of Public Health (SFDPH) is currently a recipient of the "Ryan White Act HIV/AIDS Emergency Relief Grant Program" grant in the amount of approximately $15,897,550 from the Health Resources Services Administration (HRSA) for fiscal year 2014; and

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

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

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

WHEREAS, HRSA released the application guidance on July 7, 2014 with a due date of September 19, 2014 allowing 72 days for the entire process; and

WHEREAS, In the interest of timeliness, SFDPH is making this request for approval by submitting its' most recent draft of the grant application, also including supporting documents as required, all of which are on file with the Clerk of the Board of Supervisors in File No. 140926, which is hereby declared to be part of the Resolution as if set forth fully herein; and, now, therefore, be it

RESOLVED, That the Board of Supervisors hereby approves SFDPH's application submission to HRSA for the "Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A)" grant for the funding period of March 1, 2015 through February 28, 2016, to be submitted no later than September 19, 2014.

RECOMMENDED:

Barbara A. Garcia, MPA
Director of Health

Edwin M. Lee
Mayor

TO:	**Nicole Wheaton, Director of Legislative Affairs**
FROM:	**Richelle-Lynn Mojica, Grants Manager**
DATE:	**August 13, 2014**
SUBJECT:	**Resolution authorizing the San Francisco Department of Public Health to apply for the Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A) grant**
GRANT TITLE:	**HIV Emergency Relief Grant Program (Ryan White Programs, Part A)- $36,118,233**

Enclosed, please find the original and 4 copies of the HIV Emergency Relief Grant Program (Ryan White Programs, Part A) Grant Application- $36,118,233. This is per Section 10.170.(b) of the San Francisco Administrative Code which requires Board review of proposed annual or otherwise recurring grant applications of $5,000,000 or more prior to their submission.

Should you have any questions, please contact me at Richelle-Lynn.Mojica@sfdph.org or at 415-255-3555.

Thank you.

City and County of San Francisco **Department of Public Health**

Barbara Garcia
Director of Health

July 24, 2014

Angela Cavillo, Clerk of the Board of Supervisors
Board of Supervisors
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, CA 94102-4689

RE: Resolution authorizing the San Francisco Department of Public Health (SFDPH) to apply for the HIV Emergency Relief Grant Program (Ryan White Programs, Part A).

Dear Ms. Cavillo:

Attached please find an original and four copies of a proposed resolution for the approval of the Board of Supervisors, which authorizes the San Francisco Department of Public Health (SFDPH) to submit an application for the Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A) to the Health Resources Services Administration (HRSA). This application is required to receive continued funding for the period of March 1, 2015 to February 28, 2016. This application represents approximately $36,118,233 in funding for the San Francisco Eligible Metropolitan Area (EMA). The San Francisco EMA includes the City and County of San Francisco, Marin County and San Mateo County. The funding supports a multitude of health services to HIV positive persons residing in these three counties.

This resolution is required by Ordinance No. 265-05, which amends Section 10-170 of the Administrative Code to require Board of Supervisors review of recurring grant applications of $5,000,000 or more prior to their submission. SFDPH received from HRSA the application guidance on July 9, 2014. The application deadline is September 19, 2014

I hope that the Board will support this resolution. If you have any questions regarding the County Plan or this resolution, please contact Dean Goodwin HIV Health Services Administrator at 554-9054.

Sincerely,

Barbara Garcia
Director of Health

Enclosures

cc: Bill Blum, Chief Operating Officer, Community Oriented Primary Care & Interim Director of HIV Health Services
Dean Goodwin, HIV Health Service Section Administrator
Sajid Shaikh, Sr Admin Analyst, Community Programs Business Office

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

Funding Criteria
The San Francisco Department of Public Health (SFDPH) is currently a recipient of the Ryan White HIV/AIDS HIV Emergency Relief Grant Program (Ryan White Programs, Part A) in the amount of $15,897,550 from the Health Resources Services Administration (HRSA). The Part A grant is awarded to the San Francisco Eligible Metropolitan Area which is comprised of the City and County of San Francisco, Marin County, and San Mateo County.

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

Department's Most Recent Draft of Grant Applications Materials
Please see Attachment A for the SFDPH's most recent draft of application materials. SFDPH's most recent application was submitted to HRSA on Oct 08, 2013 for the funding period of March 1, 2014 to February 28, 2015. We have received the application guidance from HRSA for the March 1, 2015 to February 28, 2016 funding period on July 9, 2014 with an application due date of September 19, 2014 .

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

Please see Attachment B for an example of the FY2013-14 Planned Service Mode Allocations for the San Francisco EMA. The service modes are defined by HRSA. The San Francisco HIV Health Services Planning Council, a citizen advisory board, is responsible for determining the priorities and the allocation of funds within each HRSA service mode for the San Francisco EMA.

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

San Francisco EMA HIV Health Services Planning Council
Membership Roster

	Affiliation	Ethnicity	Term of Office
Margot Antonetty	SFDPH- Office of Housing & Urban Health	Caucasian/white	2/1/2014 - 2/1/2016
Margaret Baran	In-Home Supportive Services Consortium, Long Term Care Coordinating Council (LTCCC) representative	Caucasian/white	8/17/2012 - 8/17/2014
Billie Cooper	Non-affiliated consumer	African American/black	10/2/2012 - 10/2/2014
Brian DiCrocco	Non-affiliated consumer	Caucasian/white	1/31/2014 - 1/31/2016
Cicily Emerson	Marin County government representative	Caucasian/white	6/23/2013 - 6/23/2015
Wade Flores	Non-affiliated consumer	Latino/a	10/30/2013 - 10/30/2015
Matt Geltmaker	Non-affiliated consumer, San Mateo County government representative	Caucasian/white	5/31/2013 - 5/31/2015
Kim Gilgenberg-Castillo	Asian & Pacific Islander Wellnes Center	Caucasian/white	7/1/2014-7/1/2016
Ron Hernandez	Non-affiliated consumer	Asian/Pacific Islander	8/17/2012 - 8/17/2014
Mary Lawrence Hicks	San Francisco General Hospital/UCSF	Caucasian/white	9/2/2012 - 9/2/2014
Kenneth Hornby	Non-affiliated consumer	Caucasian/white	9/25/2013 - 9/25/2015
Carol Hudson	Non-affiliated consumer	Latino/a	5/31/2013 - 5/31/2015
Bruce Ito	Mayor's Office of Housing & Community Development	Asian	9/24/2012 - 9/24/2014
Lee Jewell	Non-affiliated consumer	Caucasian/white	2/28/2014 - 2/28/2016
Bill Ledford	Non-affiliated consumer	Caucasian/white	9/11/2013 - 9/11/2015
T.J. Lee	San Francisco AIDS Foundation	Caucasian/white	3/24/2013 - 3/24/2015
Mayra Lopez	LYRIC	Latino/a	9/17/2013 - 9/17/2015
Rachel Matillano	N/A	Asian	6/23/2013 - 6/23/2015
Matthew Miller	Non-affiliated consumer	Caucasian/white	3/24/2013 - 3/24/2015
Catherine Newell	Non-affiliated consumer	Caucasian/white	4/30/2014 - 4/30/2016
Gabriel Ortega	Non-affiliated consumer	Latino/a	8/17/2012 - 8/17/2014
Ken Pearce	Non-affiliated consumer	Caucasian/white	9/1/2013 - 9/1/2015
John Pryor	Non-affiliated consumer	Native American	3/24/2014 - 3/24/2016
Stacia Scherich	Non-affiliated consumer	Caucasian/white	5/30/2013 - 5/30/2015
Charles Siron	Non-affiliated consumer	Asian/Pacific Islander	3/1/2014 - 3/1/2016
Michael Smithwick	Maitri	Caucasian/white	3/31/2014 - 3/31/2016

Don Soto	Lutheran Social Services	Latino/a	9/1/2013 - 9/1/2015
Chip Supanich	Shanti Project	Caucasian/white	1/25/2013 - 1/25/2015
Eric Sutter	Shanti Project	Caucasian/white	3/31/2014 - 3/31/2016
Linda Walubengo *	Larkin Street Youth Services	African American/black	Pending
Channing Wayne	Larkin Street Youth Services	African American/black	4/27/2012 - 4/27/2014

* pending approval

FY13 Part A & MAI Allocations Table

Section A: Identifying Information
San Francisco Department of Public Health, HIV Health Services
Dean Goodwin
415-437-6278
Dean.Goodwin@sfdph.org

Detailed instructions for completing and submitting this report can be found in the Electronic Handbooks and downloaded from the web at https://grants.hrsa.gov/webexternal/Login.asp

Section B: Reporting Year Award Information	
1. Part A Grant Award Amount	$17,214,125
2. MAI Grant Request / Award Amount	$710,899
3. Total Part A Funds	**$17,925,024**

Section C: Allocation Categories	1. Part A Award		2. MAI Award		3. Combined Total	
	Amount	Percentage	Amount	Percentage	Amount	Percentage
1. Core Medical Services Subtotal [1] (see CHECKLIST)	**$11,736,388**	**76.52%**	**$639,809**	**100.00%**	**$12,376,197**	**77.46%**
a. Outpatient /Ambulatory Health Services	$5,347,920	34.87%	$452,614	70.74%	$5,800,534	36.31%
b. AIDS Drug Assistance Program (ADAP) Treatments		0.00%		0.00%	$0	0.00%
c. AIDS Pharmaceutical Assistance (local)	$12,000	0.08%		0.00%	$12,000	0.08%
d. Oral Health Care	$900,408	5.87%		0.00%	$900,408	5.64%
e. Early Intervention Services	$473,426	3.09%		0.00%	$473,426	2.96%
f. Health Insurance Premium & Cost Sharing Assistance		0.00%		0.00%	$0	0.00%
g. Home Health Care	$515,561	3.36%		0.00%	$515,561	3.23%
h. Home and Community-based Health Services	$276,171	1.80%		0.00%	$276,171	1.73%
i. Hospice Services	$808,223	5.27%		0.00%	$808,223	5.06%
j. Mental Health Services	$1,518,034	9.90%		0.00%	$1,518,034	9.50%
k. Medical Nutrition Therapy		0.00%		0.00%	$0	0.00%
l. Medical Case Management (incl. Treatment Adherence)	$1,863,244	12.15%	$187,195	29.26%	$2,050,439	12.83%
m. Substance Abuse Services - outpatient	$21,401	0.14%		0.00%	$21,401	0.13%
2. Support Services Subtotal	**$3,600,425**	**23.48%**	**$0**	**0.00%**	**$3,600,425**	**22.54%**
a. Case Management (non-Medical)	$606,623	3.96%		0.00%	$606,623	3.80%
b. Child Care Services		0.00%		0.00%	$0	0.00%
c. Emergency Financial Assistance	$1,041,616	6.79%		0.00%	$1,041,616	6.52%
d. Food Bank/Home-Delivered Meals	$141,523	0.92%		0.00%	$141,523	0.89%
e. Health Education/Risk Reduction		0.00%		0.00%	$0	0.00%
f. Housing Services	$1,062,824	6.93%		0.00%	$1,062,824	6.65%
g. Legal Services	$274,995	1.79%		0.00%	$274,995	1.72%
h. Linguistics Services		0.00%		0.00%	$0	0.00%
i. Medical Transportation Services	$8,476	0.06%		0.00%	$8,476	0.05%
j. Outreach Services	$258,625	1.69%		0.00%	$258,625	1.62%
k. Psychosocial Support Services	$192,243	1.25%		0.00%	$192,243	1.20%
l. Referral for Health Care/Supportive Services		0.00%		0.00%	$0	0.00%
m. Rehabilitation Services		0.00%		0.00%	$0	0.00%
n. Respite Care		0.00%		0.00%	$0	0.00%
o. Substance Abuse Services - residential	$13,500	0.09%		0.00%	$13,500	0.08%
p. Treatment Adherence Counseling		0.00%		0.00%	$0	0.00%
3. Total Service Allocations	**$15,336,813**	**100.00%**	**$639,809**	**100.00%**	**$15,976,622**	**100.00%**
4. Non-services Subtotal	**$1,877,312**	**10.91%**	**$71,090**	**10.00%**	**$1,948,402**	**10.87%**
a. Clinical Quality Management [2] (see CHECKLIST)	$350,000	2.03%		0.00%	$350,000	1.95%
b. Grantee Administration [3] (see CHECKLIST)	$1,527,312	8.87%	$71,090	10.00%	$1,598,402	8.92%
5. Total Allocations (Service + Non-service) [4] (see CHECKLIST)	**$17,214,125**	**100.00%**	**$710,899**	**100.00%**	**$17,925,024**	**100.00%**

FY 2014 PROJECT ABSTRACT

Project Title: Furthering a Life-Saving Legacy: San Francisco EMA FY 2014 Ryan White Part A Competing Continuation Application Narrative

Applicant Name: San Francisco HIV Health Services, Bill Blum, Interim Director
HRSA Grant #: H89HA00006
Address: 25 Van Ness Avenue, Suite 500, San Francisco, CA, 94102
Contact Phone #: Office: (415) 554-9105 / Fax: (415) 431-7547
E-Mail Address: bill.blum@sfdph.org / **Web Address:** www.sfhivcare.com

Located along the western edge of the San Francisco Bay in Northern California, the San Francisco EMA is a diverse region encompassing Marin County in the north, San Francisco County in the center, and San Mateo County in the south. San Francisco County covers an area of only **47** square miles, making it geographically the smallest county in California and the sixth smallest in the US. The US Census 2010 population of the EMA is **1,776,095,** including a population of **252,409** in Marin County, **805,235** in San Francisco County, and **718,451** in San Mateo County, with widely varying population densities within the three regions. The density of San Francisco is **17,170** persons per square mile - one of the highest population densities of any city in the U.S. **Over half** of the EMA's residents are people of color, including large Asian/Pacific Islander (**26.7%**), Latino (**19.3%**), and African American (**4.3%**) populations. A large number of Asian and Latino immigrants reside in the EMA, and **42%** of EMA residents speak a language other than English at home.

As of December 31, 2012, a total of **33,469** cumulative AIDS cases had been diagnosed in the EMA, with over **22,708** persons having died of AIDS. A total of **11,582** persons were living with AIDS in the San Francisco EMA as of December 31, 2012 with roughly the same number estimated to be living with HIV, for a total of at least **23,164** persons living with HIV in the three-county region. This means that more than **1 in every 77 residents of the San Francisco EMA is infected and living with HIV.** At the epicenter of this crisis is the city and county of San Francisco, which continues to have the nation's **highest per capita prevalence of cumulative AIDS cases.**

Throughout the EMA, the emphasis on **high-quality, client-centered primary medical care services** is at the heart of the continuum of care, with 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. In Marin County, cases and services are focused around the major cities bordering the north-south-running Highway 101. San Mateo County has one HIV epicenter along its border with San Francisco and another at the opposite end of the county adjacent to East Palo Alto, with services spread out between them. In November 2005 the EMA successfully launched the **Centers of Excellence program** – an innovative network of HIV providers specifically designed to involve and retain complex, hard-to-reach, and multiply diagnosed populations in care, including an emphasis on **culturally appropriate care for ethnic minority communities.** The **seven** Centers of Excellence form a cost-effective system in which care needs can be addressed within the context of **one-stop community-based centers** in which **multidisciplinary teams** provide high levels of HIV specialist medical care, integrated with additional on-site core services designed to stabilize individuals and maintain them in treatment.

San Francisco was one of the 16 original Title I Eligible Metropolitan Areas funded by the Ryan White CARE Act in **1991** and first began receiving MAI funding in **1999.**

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

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

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

NEEDS ASSESSMENT

1) DEMONSTRATED NEED

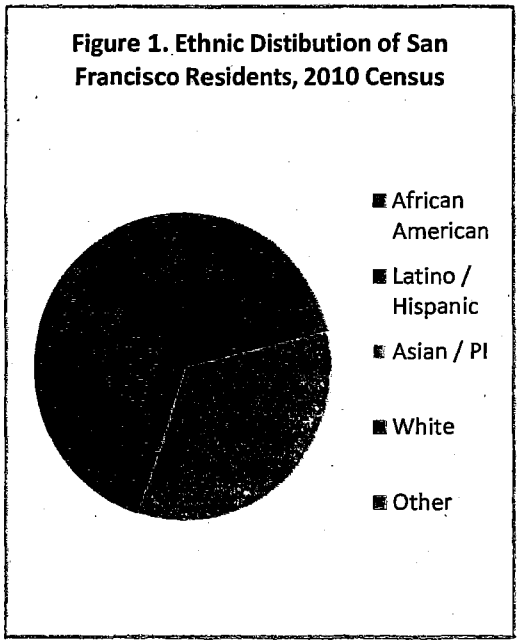
Introduction to the San Francisco EMA

Located along the western edge of the San Francisco Bay in Northern California, the San Francisco Eligible Metropolitan Area (EMA) is a unique, diverse, and highly complex region. Encompassing three contiguous counties - **Marin County** to the north, **San Francisco County** in the center and **San Mateo County** to the south - the EMA has a total land area of **1,016** square miles, an area roughly the size of Rhode Island. In geographic terms, the EMA is very narrow, stretching more than 75 miles from its northern to southern end, but less than 20 miles at its widest point from east to west. This complicates transportation and service access in the region, especially for those in Marin and San Mateo Counties. In San Mateo County, a mountain range marking the western boundary of the San Andreas Fault bisects the region from north to south, creating challenges for those attempting to move between the county's eastern and western sides. The San Francisco (SF) EMA is also unusual because of the dramatic difference in the size of its member counties. While Marin and San Mateo Counties have a land area of **520** and **449** square miles, respectively, San Francisco County has a land area of only **46.7** square miles, making it **by far the smallest county in California** geographically, and the **sixth smallest county in the US** in terms of land area. San Francisco is also one of only three major cities in the US (the others are Denver and Washington, DC) in which the city's borders are identical to those of the county in which it is located. The unification of city and county governments under a single mayor and Board of Supervisors allows for a streamlined service planning and delivery process.

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

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

native residents of Mexico, Guatemala, El Salvador, and Nicaragua. EMA-wide, **31.6%** of residents were born outside the US and **41.7%** of residents speak a language other than English at home with over **100** separate Asian dialects alone spoken in SF. Only **half** of the high school students in the City of San Francisco were born in the United States, and almost **one-quarter** have been in the country six years or less. A total of over **20,000** new immigrants join the EMA's population each year, in addition to at least **75,000** permanent and semi-permanent undocumented residents.



1.A) HIV/AIDS Epidemiology

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

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

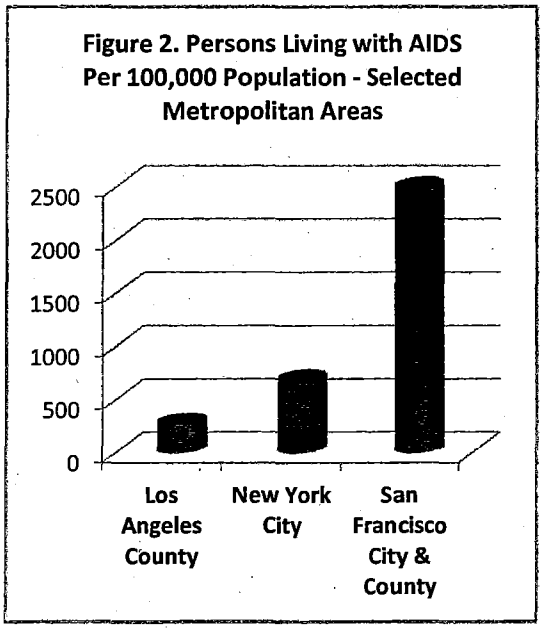
1.A.2) HIV/AIDS Epidemiology Narrative

Description of Current HIV/AIDS Cases:

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

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

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



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

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

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

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

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

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

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

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

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

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

Disproportionate Impact: In terms of ethnic minority representation, both African American and Caucasian populations are **disproportionately affected** by HIV in relation to the overall EMA population, while Latino and Asian/Pacific Islander are **underrepresented** in relation to the general population. Certainly the most dramatic over-representation occurs among **African Americans.** While only **4.3%** of EMA residents are African American, they make up **13.1%** of combined PLWHA populations in the San Francisco EMA are African American, meaning that **more than three times** the percentage of African Americans are infected with HIV as their proportion in the general population. And while **60.7%** of all PLWHA are white, only **46.7%** of EMA residents are white. By contrast, Asian/Pacific Islanders make up **26.7%** of the EMA's total population but comprise **5.6%** of PLWHA cases while Latinos constitute **18.0%** of PLWHA but make up **19.3%** of EMA residents. However, new HIV cases will soon create a disproportionate impact among Latinos as well, with **21.6%** of newly diagnosed AIDS cases occurring among Latinos between January 1, 2010 and December 31, 2012.

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

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

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

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

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

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

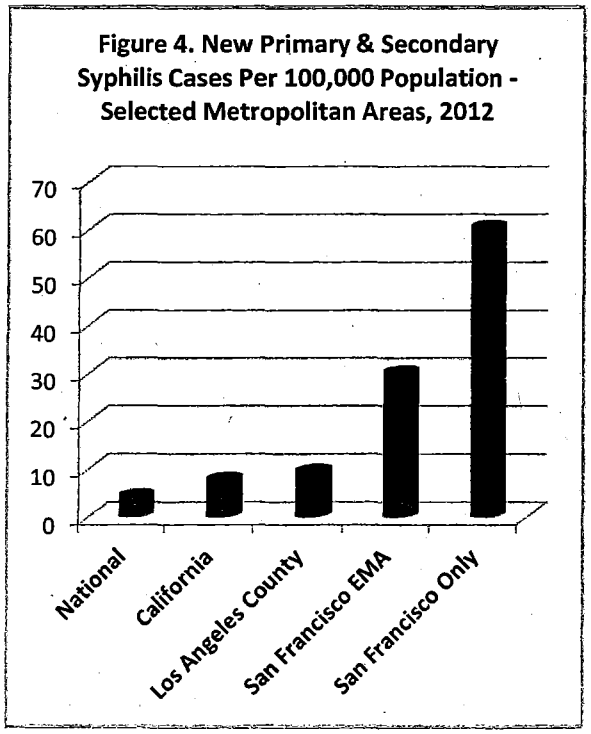
who have low incomes, with fully **95%** of survey respondents reporting that their last health care visit for HIV/AIDS had been within the past six months. While the majority of needs assessment respondents stated that they were able to access needed care services, challenges and barriers to health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

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

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

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

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

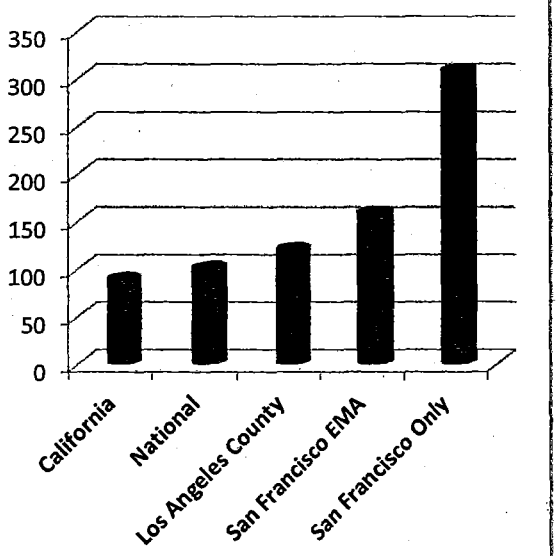


The EMA is also experiencing a significant **gonorrhea** epidemic. A total of **2,827** new gonorrhea cases were identified in the San Francisco EMA in 2012, for an EMA-wide incidence of **158.9** cases per 100,000, a rate that is nearly **100% higher** the 2012 California rate of **89.3** cases per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

The San Francisco EMA's **Chlamydia**

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

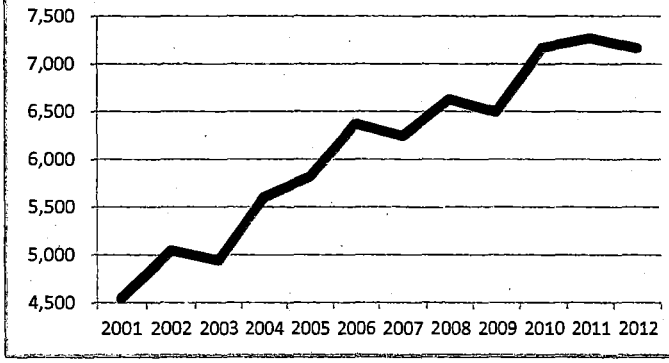
Figure 5. New Gonorrhea Cases Per 100,000 Population - Selected Metropolitan Areas, 2012



The cost of treating STIs adds significantly to the cost of HIV care in the San Francisco EMA. According to a study which estimated the direct medical cost of STIs among American youth, the total annual cost of the **9 million** new STI cases occurring among 15-24 year olds totaled **$6.5 billion** in the US, at a per capita cost of **$7,220 per person.**[25] Lissovoy, et al. estimated US national medical expenditures for congenital syphilis for the first year following diagnosis at between **$6.2 million** and **$47 million** for **4,400** cases, or as high as **$10,682** per case.[26] A study published in the *American Journal of Public Health* estimated that a total of **545** new cases of HIV infection among African Americans could be attributed to the facilitative effects of infectious syphilis, at a cost of about **$113 million**, or a per capita cost of **$20,730.**[27] Such studies suggest that the total cost of treating new STIs in the SF EMA may be as high as **$6.9 million** per year, including an estimated **$2.9 million** to treat STIs among persons with HIV, with another **$7.5 million** in annual costs potentially resulting from the need to treat persons infected with HIV as a result of transmission facilitated through other STIs.[28]

Housing and Homelessness: Housing is an indispensable link in the chain of care for persons with HIV. Without adequate, stable housing it is virtually impossible for individuals to access primary care; maintain combination therapy; and preserve overall health and wellness. These issues are more critical for persons with co-morbidities such as substance addiction or mental illness, since maintaining sobriety and medication adherence is much more difficult without stable housing. Homelessness is also a critical risk factor for HIV, with one study reporting HIV risk factors among **69%** of homeless persons.[29]

Figure 6. Annual Reported Chlamydia Cases - San Francisco EMA - 2001 - 2012



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

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

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

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

On January 24, 2013, the City of San Francisco conducted its bi-annual 24-hour homeless count which identified a total of **6,436** homeless men and women living on the streets or in jails, shelters, rehabilitation centers, or other emergency facilities, a slight decrease from the 2011 total of **6,455**.[32] At the same time, the 2013 San Mateo County Homeless Census and Survey identified a total of **2,281** homeless people on the night of January 24, 2013, including **1,229** unsheltered homeless people living on streets and **982** sheltered homeless people[33] while recent estimates place the number of homeless people in Marin County from as low as **1,770** to as high as **6,000**.[34] The City of San Francisco also serves an additional **3,000 - 7,000** temporarily homeless individuals per year, which means that - with anywhere from **9,500** to **13,500** homeless per year - the city has the **second highest per capita homelessness rate of any city in the U.S.**[35] A recent study by the University of California San Francisco found that the City's chronic homeless population has also continued to age, with a current median age among these groups estimated at **50** - up from **37** years of age when population studies first began in 1990.[36] Aging augments the progression of chronic diseases related to homelessness, including high rates of diabetes and hypertension, and complicates the problem of providing care to these groups. It is estimated that **23,540** individuals experience homelessness at some point during the year in the EMA, including an estimated **10,500** chronically homeless individuals and **13,040** temporarily homeless persons.

Homelessness has a distinct and well-established link to HIV disease. HIV prevalence studies among homeless adults in San Francisco have produced estimates ranging from a **9%** HIV prevalence rate among the general homeless adult population[37] to an astounding **41%** among marginally housed adult MSM.[38] Among the hundreds and possibly thousands of homeless youth in San Francisco - a city which still serves as a Mecca for runaway and low-income young people - estimated HIV prevalence ranges from **29%** among young homeless gay and bisexual males[39] to **68%** among gay and bisexual male teens who enter homeless youth centers.[40] **HIV disease itself also frequently results in homelessness, with the percentage of persons who were homeless at the time of AIDS diagnosis increasing in the City of San Francisco from 9% in 2006 to 14% in 2010, a more than 150% increase.**[41] Persons who were

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

The burden of **costs** that homelessness places on the local system of care is difficult to calculate, but adds significantly to the price of HIV/AIDS care. A study by the San Francisco Department of Public Health Housing and Urban Health Division found that the annual cost of medical care for homeless men and women averaged **$21,000** for inpatient, emergency department, and skilled nursing facility care, a figure which decreased to an average **$4,000** per year for individuals placed in permanent subsidized housing.[43] Meanwhile, a two-year University of Texas survey of homeless individuals found that the public cost of caring for the homeless averaged **$14,480** per person per year, primarily for overnight jail stays.[44] Overall, SF DPH estimates that the total costs of homelessness add at least an additional **$16.2 million** to the cost of care for HIV-positive individuals within the EMA – costs that do not take into account the higher rates of HIV infection among homeless populations.[45]

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

The lack of health insurance places extreme financial burden on the system, particularly in the San Francisco EMA, which has extremely high medical costs. In addition, because of the current financial crisis, the numbers of persons who have lost private insurance as a result of unemployment or reduced employment based health insurance benefits has dramatically increased the number of uninsured persons in the State over the past two years. While approximately **half** of San Francisco Ryan White system clients are covered by Medicaid, roughly **one-quarter** lack **any** form of insurance coverage. At the same time, for those persons with HIV not in care or unaware of their HIV status, the uninsured rate is believed to be much higher than the general population as many HIV-infected people in the EMA are poor, not in care, and/or have not yet applied for Medicaid. SF DPH estimates that the **cost** to the system of serving uninsured and indigent populations living with HIV is at least **$91.5 million** annually, based on an average **25.1%** uninsured rate among PLWHA in care (n=**4,576**) at an estimated annual avg. cost of **$20,000** per person for HIV treatment and medications.

Poverty: The problem of homelessness is closely tied to that of **poverty**, and presents another daunting challenge to the HIV care system. According to the 2010 Census, the average percentage of persons living at or below federal poverty level stands at **9.2%** for the entire San Francisco EMA. Using this data, SF DPH projects that at least **490,201** individuals in the San Francisco EMA are living at or below 300% of Federal Poverty Level, which translates to **27.6%** of the overall EMA population lacking resources to cover all but the most basic expenses. **However, because of the high cost of living in the San Francisco Bay Area, persons at 300%**

of poverty or below have a much more difficult time surviving in our area than those living at these income levels in other parts of the U.S. Analyzing data from the San Francisco AIDS Regional Information and Evaluation System (ARIES),the SF EMA's client-level data system, it is estimated that at least **68.9%** of all persons living with HIV/ AIDS in the San Francisco EMA (n=**15,960**) are living at or below 300% of the 2013 Federal Poverty Level (FPL) including persons in impoverished households. **100%** of Ryan White-funded clients live at or below 300% of poverty.[47] ARIES data reveals that **over half (55.2%)** of active Ryan White clients in the San Francisco are currently living at or below 100% of FPL while another **30.5%** are living between 101% and 200% of FPL. HIV-infected persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **$69 million** in Part A and non-Part A HIV-related expenditures in the San Francisco EMA each year.[48]

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

1.B.3) Impact of Formerly Incarcerated Individuals

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

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

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

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

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

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

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

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

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

Coordination with Other Federal and State Resources: The San Francisco HIV Health Services Planning Council and the SF Department of Public Health work together to ensure that Ryan White Part A funds are coordinated across all applicable funding streams in the region. The

Planning Council also reviews annual service category summaries that include a detailed listing of all Ryan White and non-Ryan White funding sources for each category, including sources such as ADAP, Medicaid and Medicare support, public entitlement programs, private insurance and HMO support, Veterans Administration programs, City and County funds, HOPWA and SAMHSA grants, and State mental health funds. The Grantee also ensures that services are coordinated to maximize the number and accessibility of services, while seeking every possible alternate source of funding apart from Part A to support HIV care.

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

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

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

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

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

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

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

1.D) Assessment of Populations with Emerging Needs

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

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

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

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

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

Demographic Categories	Number	Percent
Gender		
Male	9,235	92.5%
Female	613	6.1%
Transgender	137	1.4%
Ethnicity		
White	6,804	68.1%
African American	1,463	14.7%
Latino	1,219	12.2%
Asian / Pacific Islander	352	3.5%
Other / Unknown	147	1.5%
Transmission Categories		
MSM	7,258	72.7%
Injection Drug Users	868	8.7%
MSM Injection Drug Users	1,2620	12.6%
Non-IDU Heterosexuals	346	3.5%
Other / Unidentified	251	2.5%
Time Since 1st HIV Diagnosis		
0 - 2 Years	246	2.5%
3 - 5 Years	437	4.4%
6 - 10 Years	1,169	11.7%
11 - 15 Years	2,012	20.2%
16 - 20 Years	3,113	31.2%
More Than 20 Years	3,008	30.1%
TOTAL	**9,985**	**100.0%**

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

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

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

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

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

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

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

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

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

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

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

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

MSM of color in the San Francisco EMA tend to be poorer; have less access to preventive health care; have lower rates of private insurance; and have higher levels of co-morbidities. MSM of color are also believed to have significantly higher levels of unmet need than white MSM. Prior needs assessments have found that perceived **structural barriers,** such as restrictive or complex rules for entering service, and perceived **lack of service access** were cited most frequently as barriers to care for MSM of color, with more than **half** of assessment respondents saying they were likely to have a problem related to these factors. Lack of insurance; the high cost of care; not knowing services are available; and perceived lack of confidentiality were cited as particular barriers to care among MSM who reported being out of care **for a year or more.** The annual **cost** of providing HIV-related services to men of color who have sex with men within the SF EMA is estimated at **$73,448,100.**[58]

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

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

compared to **6.5%** for the EMA as a whole, while heterosexually transmitted cases account for **9.7%** of African American PLWHA as compared to **3.9%** for the entire EMA. At least **30%** of all African Americans living with HIV in the San Francisco EMA are currently estimated to be out of care - a proportion comparable to the percentage of homeless persons out of care. The reasons for this under-representation include: a) continuing high rates of stigma within African American communities related both to HIV and the behaviors that transmit it; b) higher prevailing rates of poverty and unemployment, leading to lower rates of private insurance and health care utilization; and c) high rates of injection drug use and homelessness, leading to difficulty in accessing or prioritizing care. Of the 183 African Americans surveyed for the EMA's 2008 Needs Assessment, **49.3%** reported having no insurance of any kind, and **53.3%** reported a high or complete disconnection from care, with frequently cited barriers including: fear of governmental health services; lack of culturally competent services; racial discrimination; frustration with long waiting lists; and a lower prioritization of health care due to competing needs driven by poverty and racism. To successfully reach more HIV-infected African Americans, the local care system has had to engage in a more aggressive and comprehensive approach by locating culturally appropriate services within historically black neighborhoods to inform African Americans of the importance of HIV testing and proactively engaging them in treatment. **The Black Center of Excellence at the University of California San Francisco, supported with Ryan White Part A funds, are making a significant contribution toward addressing this discrepancy.** In addition, in 2010, the San Francisco Planning Council completed an **African American Women's Needs Assessment** which significantly expanded our understanding of the needs and life circumstances of this population and aided in the prioritization and allocation of service funding. The annual **cost** of providing HIV-related services to African Americans within the SF EMA is estimated at **$38,322,000.**[60]

Emerging Population # 6: Latinos: In the San Francisco EMA, the Latino population makes up a growing percentage of the region's total HIV-infected population. While **18.0%** of all PLWHA in the EMA as of December 31, 2012 were Latino/a, **21.6%** of new AIDS cases diagnosed between January 1, 2010 and December 31, 2012 were among Latino/as. A total of **4.162** Latino/a PLWHA estimated to be living in the EMA as of the end of 2012. According to the most recent San Francisco HIV Epidemiology Report, Latinos represent **31%** of young adult AIDS cases age 20-24 in the city and an alarming **44%** of adolescent AIDS cases age 13-19 – a clear overrepresentation when compared to the **26%** of the general adolescent population of San Francisco which is Latino/a. As with African American populations, a lack of access to health care, higher rates of poverty and unemployment, and a disconnection from health and social services contribute to relatively high rates of unmet need in the Latino population. According to the US Census, in the City of San Francisco, **11.1%** of the city's population speaks Spanish as their primary language, with **26.5%** of those who speak Spanish as their primary language reporting they speak English either not well or not at all. This requires that HIV services be provided in Spanish by culturally competent professionals who understand the health beliefs and practices of Latino communities. Fear of jeopardizing naturalization opportunities also leads to a reluctance to seek HIV testing or treatment. The **Mission Center of Excellence** operated by Mission Neighborhood Health Center and funded through MAI funding provides culturally competent, integrated, bilingual/bi-cultural HIV services to over **400** Mission neighborhood residents, with an emphasis on Spanish-speaking clients, in order to enhance their quality of life and promote individual and community empowerment. The annual **cost** of providing HIV-related services to Latino populations in the SF EMA is estimated at **$56,196,500.**[61]

1.E) Unique Service Delivery Challenges

The San Francisco EMA HIV system of care - a system that has served for decades as a national model of effective HIV service delivery - is facing an economic crisis which threatens both the quality and availability of care for persons with HIV/AIDS in the region. This crisis stems from a convergence of factors creating an environment in which the system is unable to meet the needs of the HIV-infected populations it was designed to serve, including being unable to bring the most needy and underserved populations into medical care and retain them on combination therapies. The factors underlying this threat fall into **three** broad categories: **1)** The growing population of persons living with HIV infection, including individuals with complex and multiple needs; **2)** Escalating co-morbidities which threaten to swamp the system and create overwhelming demands on care providers, including increasing number of persons with HIV age 50 and older; and **3)** The concentration of HIV and AIDS cases within a relatively small geographic area, especially in the case of San Francisco. Each of these issues - described briefly below - places a particular burden on the system of care, and presents challenges to a Planning Council struggling to maintain an adequate level of support for **all** impoverished persons with HIV. California's massive 2009 health and human service funding cuts – including reductions of **$59.1 million** in support for HIV/AIDS programs throughout the state – only complicate the ongoing challenge of delivered effective, life-prolonging care to a growing and increasingly impoverished population.

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

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

Ironically, it is in part because the San Francisco system of care has been so successful at bringing people into care and preserving their health that the system faces the

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

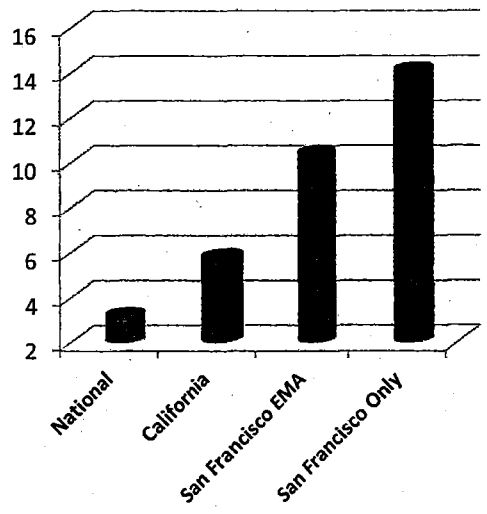
Escalating Co-Morbidities: Section 1.B above describes several co-morbidities critical to the complexity of providing care in the San Francisco EMA. However, these are by no means the only key issues contributing to the growing complexity of the HIV epidemic in San Francisco. The problem of **substance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

The costs associated with the substance addiction epidemic in the San Francisco EMA add significantly to the local burden of HIV care. According to the National Office on Drug Abuse (NIDA), the total costs of drug abuse and addiction due to use of tobacco, alcohol, and illegal drugs are estimated at **$524 billion** a year and illicit drug use alone accounts for **$181 billion** in health care costs, lost productivity, crime, incarceration, and drug enforcement.[76] The National Institute on Drug Abuse reports that it costs an average of **$3,600 per month** to leave a drug abuser untreated in the community; while incarceration related to substance use costs approximately **$3,300 per month.**[77] Such costs can be significantly offset by drug treatment services, which are estimated to save between **$4** and **$7** for every dollar spent on treatment. An average course of methadone maintenance therapy, for example, costs about **$290** per month, while a range of methamphetamine treatment programs in San Francisco cost between **$2,068** and **4,458** for a single course of treatment.[78]

Injection drug use in the San Francisco EMA is closely related to the growing local epidemic of **hepatitis C**. Because it is a blood-borne infection, hepatitis C is closely tied to injection drug use, and is a frequent co-factor for persons living with HIV/AIDS, complicating care and often leading to severe long-term health consequences. **SF DPH estimates that as**

many as 90% of all chronic injection drug users over the age of 30 may already be infected with hepatitis C. Co-infection with hepatitis C can make persons living with HIV unable to tolerate new treatments, and is the leading cause of death from chronic liver disease in America.[79] Existing hepatitis C treatments are also costly, and are effective for only about **50%** of people who take them. A single 48-week treatment course of injected interferon and oral ribavarin costs more than **$20,000.**[80] One study estimated a total of **$10.7 billion** in direct medical care costs related to HCV in the US for the years 2010 to 2019, along with a combined loss of **1.83 million years of life** in those younger than 65 at a societal cost of **$54.2 billion.**[81] **The HIV care system is rapidly becoming the default medical provider for many persons with hepatitis C - a trend which, as persons with HCV age, will place enormous cost burdens on the system.**

Figure 11. 2011 Tuberculosis Cases Per 100,000 Population - Selected Metropolitan Areas



Tuberculosis (TB) is another critical health factor linked to HIV, particularly in terms of its effects on recent immigrants and the homeless. The magnitude of the local TB crisis is comparable to syphilis and gonorrhea, with a total of **185** new cases of TB diagnosed in the SF Metropolitan Area in 2012, representing an EMA-wide incidence of **10.4** cases per 100,000.[82] In San Francisco, the incidence is even higher, at **14.1** cases per 100,000. San Francisco County's 2012 TB rate ranked second in California out of 58 counties, while San Mateo ranked seventh and Marin County ranked 14th. **San Francisco's TB incidence rate is more than double than the statewide rate of 5.8 cases per 100,000 and nearly four times higher than the national rate of 3.2 cases per 100,000** (see Figure 11).[83] Treatment for **multidrug-resistant tuberculosis** is particularly expensive, with one study indicating that the cost averaged **$89,594** per person for those who survived, and as much as **$717,555** for patients who died.[84]

The high prevalence of **mental illness** and **mental health issues** in the San Francisco EMA further complicates the task of delivering effective services and retaining persons with HIV in care. The San Francisco Department of Public Health, Behavioral Health Section reported in its most recent report that **12,000** seriously emotionally disturbed children and youth and **32,000** seriously mentally ill adults live in San Francisco, and that up to **37%** of San Francisco's homeless population suffers from some form of mental illness.[85] In part because of the Golden Gate Bridge, San Francisco also has one of the nation's highest rates of both adult and teen suicide completion, and the rate of suicide per capita in San Francisco is **twice as high** as the city's homicide rate.[86] When coupled with the second highest incidence of homelessness in the US, these statistics reflect the high incidence of multiply diagnosed clients in the EMA. Among persons with severe mental illness, the research literature documents a broad range of HIV seroprevalence rates, from **4%** to as high as **23%.**[87] Mental illness, depression, and dementia are also increasingly common among HIV-diagnosed populations, with **31%** of HIV clients at one San Francisco clinic having concomitant mental illness, and **80%** of clients at another clinic having a major psychiatric condition. One recent study found a **37%** prevalence of depression in HIV-infected men in San Francisco.[88]

Concentration of HIV/AIDS Cases: Imagine standing in a crowded bus or train during rush hour in a major U.S. city. On that train in San Francisco, the odds are extremely high that at least **two** people will have HIV. As noted above, **1 in every 40** residents of the city is currently living with HIV disease, including as many as **one out of every three** gay-identified men. In most major U.S. cities, the burden of the HIV epidemic is spread across a relatively large region, with more facilities available to provide care for broadly dispersed groups of patients. The City of San Francisco, however, is **less than seven miles long by seven miles wide,** which means that this population must be cared for within a very limited space that has fewer health and social service facilities available to meet client needs. In San Francisco, the concentrated demand results in HIV services being compressed within individual provider agencies that are struggling to cope with HIV caseloads many times larger than they were originally established to serve. Lag times between initial inquiries and appointments are becoming progressively longer, and clients are experiencing greater delays in obtaining key services. The increasing complexity of HIV-infected populations also means that local agencies must cobble together combinations of full-time and part-time staff, resulting in higher levels of employee turnover and attrition.

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

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

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

1.G) UNMET NEED

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

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

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

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

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

Methods for Estimating Met and Unmet Need for Primary Medical Care: In accordance with HRSA guidelines, PLWA and PLWH were considered to have a **met** need for HIV primary medical care if any data source indicated that they received antiretroviral therapy or had at least one CD4 or viral load test during the **12-month period from July 1, 2011 through June 30, 2012**. Separate unmet need estimates for PLWA and PLWH could be generated as all population and care data sources contained information on AIDS/HIV status. The number of PLWA in care for Marin County and San Mateo was calculated as the number of unduplicated persons who received care based on all data sources. To determine the number of PLWA

receiving care in San Francisco, the proportion of PLWA in care was calculated using a representative subset of PLWA living in San Francisco County (n=8,470). The proportion of PLWA receiving care as determined in the sample was then applied to the total number of PLWA to derive the number of PLWA who received care in San Francisco. For all counties in the EMA, the number of PLWH in care was calculated as the number of unduplicated persons who received care based on all data sources. Estimates for PLWA and PLWH were first derived separately for each of the three EMA counties and then combined to produce the EMA estimates shown in the unmet need table in **Attachment 6**.

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

1.G.3) Unmet Need Trends

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

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

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

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

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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

HIV/AIDS Bureau
Division of Metropolitan HIV/AIDS Programs

Ryan White Part A
HIV Emergency Relief Grant Program

Announcement Type: Competing Continuation
Announcement Number: HRSA-15-003

Catalog of Federal Domestic Assistance (CFDA) No. 93.914

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2015

Application Due Date: September 19, 2014

Modified on 8/28 to indicate that the Budget Narrative should be attached only to the Budget Narrative attachment form. Applicants do not need to attach the budget narrative as Attachment 12. Corrections have been made on pages 30 and 34 (in red, bold and underlined text).

Ensure SAM.gov Grants.gov registration and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration in all systems, including SAM.gov and Grants.gov,
may take up to one month to complete.

Release Date: July 7, 2014

Issuance Date: July 7, 2014

Steven R. Young, MSPH
Director, Division of Metropolitan HIV/AIDS Programs
Email: SYoung@hrsa.gov
Telephone: (301) 443-9091
Fax: (301) 443-5271

Authority: Public Health Service Act, Sections 2601-2610 (42 USC 300ff-11 – 300ff-20), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87)

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB)/Division of Metropolitan HIV/AIDS Programs is accepting applications for the fiscal year (FY) 2015 Ryan White Part A HIV Emergency Relief Grant Program. The purpose of this grant program is to: provide direct financial assistance to an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA) that has been severely affected by the HIV epidemic.

Funding Opportunity Title:	Ryan White Part A HIV Emergency Relief Grant Program
Funding Opportunity Number:	HRSA-15-003
Due Date for Applications:	September 19, 2014
Anticipated Total Annual Available Funding:	$618,492,359
Estimated Number and Type of Award(s):	52 grants
Estimated Award Amount:	Varies
Cost Sharing/Match Required:	No
Project Period:	3/1/2015-2/28/2016 (1 year)
Eligible Applicants:	Part A Grantees that are classified as an EMA or as a TGA and continue to meet the statutory requirements are eligible to apply for these funds. [See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]

All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide,* available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf, except where instructed in this funding opportunity announcement to do otherwise. A short video for applicants explaining the new *Application Guides* is available at http://www.hrsa.gov/grants/apply/applicationguide/.

All applicants are encouraged to participate in a technical assistance (TA) webinar for this funding opportunity. The technical assistance webinar is tentatively scheduled for August 7, 2014 from 2-4PM Eastern Time. The purpose of this webinar is to assist potential applicants in preparing applications that address the requirements of this funding announcement. Participation in a pre-application TA webinar is optional.

Dial-in Phone Number: 1-800-857-6259
Passcode: 7527379
To access the webinar online, go to the Adobe Connect URL:
https://hrsa.connectsolutions.com/2015FOA/

Table of Contents

I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for the Ryan White Part A HIV Emergency Relief Grant Program. Part A funds provide direct financial assistance to an eligible metropolitan area (EMA) or a transitional grant area (TGA) that has been severely affected by the HIV epidemic. Grants assist eligible program areas in developing or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families with HIV through the provision of formula, supplemental, and Minority AIDS Initiative (MAI) funds. A comprehensive continuum of care includes the 13 core medical services specified in law, and appropriate support services that assist people living with HIV and AIDS (PLWH) in accessing treatment for HIV/AIDS infection that is consistent with the Department of Health and Human Services (HHS) Treatment Guidelines. (See http://www.aidsinfo.nih.gov). Comprehensive HIV/AIDS care beyond these core services may include supportive services that meet the criteria of enabling individuals and families living with HIV/AIDS to access and remain in primary medical care to improve their medical outcomes.

HRSA/HAB recognizes that Part A EMAs and TGAs must use grant funds to support and further develop and/or expand systems of care to meet the needs of PLWH within the EMA/TGA and strengthen strategies to reach minority populations. HAB has required EMAs/TGAs to collect data to support identification of need, for planning purposes, and to validate the use of Ryan White HIV/AIDS Program funding. A comprehensive application should reflect how those data were used to develop and expand the system of care in EMA/TGA jurisdictions. Grantees should review/reference relevant needs assessments conducted by other HIV/AIDS programs, such as HRSA's Bureau of Primary Health Care, Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), and the U.S. Department of Housing Urban Development.

Ongoing CDC initiatives, as well as HAB's efforts with grantees to estimate and address Unmet Need of those aware of their HIV status and the newer requirement to identify and bring into care persons in their jurisdictions who are unaware of their positive HIV status, should result in many more PLWH entering into the EMA/TGA care system. The EMA/TGA planning process must ensure that essential core medical services have been adequately funded to meet the needs of those already in care and those being linked to care.

As of March 2014, the CDC estimates more than 1.1 million people are living with HIV and 1 in 5 people do not know their HIV status. The ultimate goal of the United States (U.S.) Public Health Service's (PHS) is to inform all HIV-positive persons of their status and bring them into care in order to improve their health status, prolong their lives, and slow the spread of the epidemic in the U.S. through enhanced prevention efforts. A list of CDC initiatives can be found at http://www.cdc.gov/hiv/topics/prev_prog/index.htm.

Important Notes:

- In accordance with the Ryan White HIV/AIDS Program legislation (Sec. 2603 (a)(4)) of the PHS Act hold harmless will not be a factor in the FY 2015 Ryan White Part A awards.
- Information on Ryan White and the Affordable Care Act, along with Policy Clarification Notices can be found at http://hab.hrsa.gov/affordablecareact/.

- The Early Identification of Individuals with HIV/AIDS (EIIHA) requirements in this funding announcement have been updated and streamlined. These requirements are included in section 2.B. of the Needs Assessment. Please review carefully when preparing this section of your application.

- Information on the National HIV/AIDS Strategy (NHAS) is located in the SF-424 Application Guide.

- Greater emphasis has been placed on the HIV Care Continuum. Applicants are expected to include a graph illustrating the HIV Care Continuum in the EMA/TGA and an explanation of how the Continuum is utilized in your jurisdiction at present or plans to integrate it into future use. **As this is a new section it will not be scored for the FY 15 FOA.** Refer to the Work Plan section for requirements.

The following information will assist in understanding and completing this year's grant application:

- Grantees are required to have implemented the Part A National Monitoring Standards at the grantee and provider/sub-recipient levels. HRSA has developed and distributed guidelines outlining the responsibilities of HRSA, the grantee, and provider staff. The National Monitoring Standards can be found at: http://hab.hrsa.gov/manageyourgrant/granteebasics.html.

- Women, Infants, Children and Youth (WICY) waiver requests are no longer part of the application process. The WICY waiver reporting format was revised to allow grantees to submit a waiver request and provide supporting data with the annual progress report.

- Part A funds are subject to Section 2604(c) of the PHS Act which requires that not less than 75 percent of the funds be used to provide core medical services that are needed in the EMA/TGA for individuals with HIV/AIDS who are identified and eligible under the Ryan White HIV/AIDS Program. Core medical services are listed in section 2604(c)(3) of the PHS Act, and support services allowed under Part A are limited to services that are needed for individuals with HIV/AIDS to achieve their medical outcomes, as defined by the Ryan White HIV/AIDS Program. The most recent service definitions can be found in the latest version of the National Monitoring Standards.

- Applicants seeking a waiver to the core medical services requirement must submit a waiver request either with this grant application, at any time up to the application submission, or up to 4 months after the start of the grant award for FY 2015. Submission should be in accordance with the information and criteria published by HRSA in the Federal Register Notice, Vol. 78, No. 101, dated Friday, May 24, 2013, and may be found at http://www.gpo.gov/fdsys/pkg/FR- 2013-05-24/pdf/2013-12354.pdf. Sample letters may be found at http://hab.hrsa.gov/affordablecareact/samplereqwaiverletters.pdf. In addition, grantees are advised that a FY 2015 Part A waiver request must include funds awarded under the Minority AIDS Initiative (MAI). A waiver request that does not include MAI will not be considered. If submitting with the application, a core medical services waiver request should be included as **Attachment 8**.

- EMA/TGA Agreements and Compliance Assurances are included (**Appendix A**) with this funding opportunity announcement (FOA), and require the signature of the CEO, or the CEO's designee; this document should be included as **Attachment 2**.

2. Background

This program is authorized by the Public Health Service Act, Sections 2601-2610 (42 USC 300ff-11– 300ff-20), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 11-87), (hereafter referred to as the Ryan White HIV/AIDS Program). Part A grants to EMAs and TGAs include formula and supplemental components, as well as MAI funds which support services targeting minority populations. Formula grants are based on living HIV/AIDS cases, as of December 31, in the most recent calendar year for which data are available, as reported to and confirmed by the CDC. Therefore, applicants are required to report on the number of persons living with HIV and AIDS in their jurisdictions. Supplemental grants are awarded competitively on the basis of demonstrated need and other criteria. MAI funding is awarded using a formula that is based on the distribution of living HIV/AIDS cases among racial and ethnic minorities. In each EMA, local planning councils (PC) set priorities and allocate Part A funds on the basis of the size, demographics, and needs of the population living with or affected by HIV. TGAs are required to use a community planning process. While the use of PCs is optional pending further direction from statutory provisions, and/or appropriations language, TGAs that have currently operating PCs are strongly encouraged to maintain that structure. Applicants are reminded that MAI funds should be fully integrated into Part A planning, priority setting and allocation processes. The legislation can be obtained at: http://www.gpo.gov/fdsys/pkg/USCODE-2011-title42/html/USCODE-2011-title42-chap6A-subchapXXIV.htm.

Affordable Care Act (ACA)

As part of the Affordable Care Act (ACA), the health care law enacted in 2010, several significant changes have been made in the health insurance market that expand options for health care coverage, including those options for people living with HIV/AIDS. The ACA creates new state-based marketplaces, also known as exchanges, to offer millions of Americans access to affordable health insurance coverage. Under the ACA individuals with incomes between 100 to 400 percent Federal Poverty Level (FPL) may be eligible to receive advance payments of premium tax credits and/or cost-sharing reductions to help pay for the cost of enrolling in qualified health insurance plans and for coverage of essential health benefits. In states that choose to participate, Medicaid eligibility expands to non-disabled adults with incomes of up to 133 percent of FPL providing new coverage options for many individuals who were previously ineligible for Medicaid. In addition, the law requires health plans to cover certain recommended preventative services without cost sharing making health care affordable and accessible for Americans. These health care coverage options may be reviewed at http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf.

Outreach efforts are needed to ensure that families and communities understand these new health care coverage options and to provide eligible individuals assistance to secure and retain coverage. The HIV/AIDS Bureau recognizes that outreach to and enrollment of Ryan White HIV/AIDS Program (RWHAP) clients into the expanded health insurance coverage is critical. As appropriate and allowable by statute, RWHAP grantees are strongly encouraged to support ACA-related outreach and enrollment activities to ensure that clients fully benefit from the new

health care coverage opportunities. For more information on allowable outreach and enrollment activities, please see http://www.hab.hrsa.gov/affordablecareact/outreachenrollment.html.

Applicants are expected to include a description of plans for outreach and enrollment of RWHAP clients into new health coverage options. Current grantees should describe how they will help their clients take advantage of new health coverage opportunities. Grantees and sub-grantees should also assure that individual clients are enrolled in any appropriate health care coverage whenever possible or applicable, and informed about the financial or coverage consequences if they choose not to enroll.

For more information on the marketplaces and the health care law, visit http://www.healthcare.gov.

HIV Care Continuum

Identifying people infected with HIV and linking them to HIV primary care with initiation and long-term maintenance of life-saving antiretroviral treatment (ART), are important public health steps toward the elimination of HIV in the United States. The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the HIV Care Continuum or the Care Treatment Cascade. The HIV Care Continuum includes the diagnosis of HIV, linkage to HIV medical care, lifelong retention in HIV medical care, appropriate prescription of ART, and ultimately HIV viral load suppression.

The difficult challenge of executing these lifesaving steps is demonstrated by the data from the CDC, which estimate that only 25 percent of individuals living with HIV in the United States have complete HIV viral suppression. Data from the Ryan White Service Report (RSR) indicate that there are better outcomes in Ryan White HIV/AIDS Program (RWHAP) funded agencies with approximately 70% of individuals who received RHWAP-funded medical care being virally suppressed. Such findings underscore the importance of supporting effective interventions for linking HIV-positive individuals into care, retaining them in care, and helping them adhere to their combination antiretroviral regimens.

RWHAP grantees are encouraged to assess the outcomes of their programs along this continuum of care. Grantees should work with their community and public health partners to improve outcomes across the Continuum of HIV Care, so that individuals diagnosed with HIV are linked and engaged in care and started on ART as early as possible. HAB has worked with other agencies within the Department of Health and Human Services (HHS) to develop performance measures to assist in assessing outcomes along the continuum. HAB encourages grantees to use these performance measures at their local level to assess the efficacy of their programs and to analyze and address the gaps along the HIV Care Continuum to improve the care outcomes provided. These efforts are in alignment with the support and goals and objectives of the National HIV/AIDS Strategy.

The HIV Care Continuum measures also align with the HHS Common HIV Core Indicators approved by the before Secretary and announced in August 2012. RWHAP grantees and providers are required to submit data through the Ryan White Services Report (RSR). Through the RSR submission, HAB currently collects the data elements to produce the HHS Common HIV Core Indicators. HAB will calculate the HHS Core Indicators for the entire RWHAP. HAB will use these data to report six of the seven HHS Common HIV Core Indicators to the Department of Health and Human Services, Office of the Secretary for Health.

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding during Federal fiscal year 2015. Approximately $618,492,359 is expected to be available to fund fifty-two (52) grantees. The actual amount available will not be determined until enactment of the final FY 2015 Federal budget. This program announcement is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, applications can be processed, and funds can be awarded in a timely manner. The project period is one (1) year. Supplemental funding for Part A is available on a competitive grant application basis to EMAs/TGAs whose applications address the following legislative criteria:

a) contains a report concerning the dissemination of the Part A formula funds, and the plan for utilization of such funds;
b) demonstrates need in the area, on an objective and quantified basis for supplemental financial assistance to combat the HIV epidemic;
c) demonstrates the existing commitment of local resources of the area, financial and in-kind to combating the HIV epidemic;
d) demonstrates the ability of the area to utilize such supplemental financial resources in a manner that is immediately responsive and cost effective;
e) demonstrates that resources will be allocated in accordance with the local demographic incidence of AIDS, including appropriate allocations for services for women, infants, children, youth (WICY), and families with HIV/AIDS;
f) demonstrates the inclusiveness of affected communities and individuals living with HIV and AIDS;
g) demonstrates the manner in which the proposed services are consistent with the local needs assessment and the Statewide Coordinated Statement of Need;
h) demonstrates the ability of the applicant to expend funds efficiently by not having had, for the most recent Part A formula grant year, for which data is available, more than five percent of grant funds unobligated at the end of the year, even if a request for carryover was granted; and
i) demonstrates success in identifying individuals living with HIV and AIDS who are unaware of their HIV/AIDS status, and provides a description of the strategy, plan, and data associated with the early identification of these individuals.

III. Eligibility Information

1. Eligible Applicants

Part A Grantees who are classified as an EMA or as a TGA, and continue to meet the statutory requirements are eligible to apply for these funds. For an EMA, this is more than 2,000 cases of

AIDS reported and confirmed during the most recent 5 calendar years, and for a TGA, this is at least 1,000, but fewer than 2,000 cases of AIDS reported and confirmed during the most recent period of 5 calendar years for which such data are available. Additionally, for three consecutive years, grantees must not have fallen below the required incidence levels already specified, and required prevalence levels (cumulative total of living cases of AIDS reported to and confirmed by the Director of the CDC, as of December 31 of the most recent calendar year for which such data are available); for an EMA, this is 3,000 living cases of AIDS, and for a TGA, this is 1,500 living cases of AIDS, or at least 1,400 (and fewer than 1,500) living cases, as long as the area did not have more than 5 percent of the total amount from grants awarded to the area under this part unobligated, as of the end of the most recent fiscal year.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Multiple applications from an organization are not allowable.

Maintenance of Effort (MOE)
The Ryan White HIV/AIDS Program legislation requires Part A Grantees to maintain, as a Condition of Award, EMA/TGA political subdivision expenditures for HIV-related core medical services and support services at a level equal to the 1-year period preceding the FY for which the grantee is applying to receive a Part A grant. After enactment of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Section 2604(b)(1) of the PHS Act states: "In general – The chief elected official of an eligible area shall use amounts from a grant under Section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services." Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the legislation and the HIV/AIDS Bureau service definitions distributed to all grantees. Part A Grantees must document they have met the maintenance of effort (MOE) requirement.

To demonstrate that grantees understand this revision to the Part A MOE requirement, applicants must submit the following information:

a) A table that identifies the MOE budget elements and the amount of expenditures related to core medical services and support services for FYs 2012 and 2013, and;
b) A description of the process used to determine the amount of expenditures reported in the table.

This requirement is included as part of the Organizational Information section of this FOA.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** applicants for this funding opportunity announcement to apply electronically through Grants.gov. Applicants must download the SF-424 application package associated with this funding opportunity following the directions provided at Grants.gov.

2. Content and Form of Application Submission

Section 4 of HRSA's *SF-424 Application Guide* provides instructions for the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program specific information below. All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide* except where instructed in the funding opportunity announcement to do otherwise.

Application Page Limit
The total size of all uploaded files may not exceed the equivalent of 100 pages when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this FOA. Standard OMB-approved forms that are included in the application package are NOT included in the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) will not be counted in the page limit. **We strongly urge you to print your application to ensure it does not exceed the specified page limit.**

Applications must be complete, within the specified page limit, and validated by Grants.gov under the correct funding opportunity number prior to the deadline to be considered under the announcement.

Program-Specific Instructions
In addition to application requirements and instructions in Section 4 of HRSA's *SF-424 Application Guide* (including the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract), please include the following:

i. Project Abstract
See Section 4.1.ix of HRSA's *SF-424 Application Guide*. In addition to the instructions in section 4.1.ix of HRSA's *SF-424 Application Guide,* please include a project abstract, with the following information in this order:

a) general demographics of EMA/TGA;
b) demographics of HIV/AIDS populations in the EMA/TGA;
c) geography of the EMA/TGA with regard to communities affected by HIV/AIDS and the location of HIV/AIDS services in relation to those communities, including minority populations served with Minority AIDS Initiative (MAI) funds;
d) description of the continuum of care offered in the EMA/TGA, including relevant information about the primary medical care services, how HIV primary care services are delivered, and how clients are supported in accessing and remaining in care; and

e) number of years the EMA/TGA has received Part A and MAI funding.

ii. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Use the following section headers for the Narrative:

- *INTRODUCTION -- Corresponds to Section V's Review Criterion #1*
  This section should briefly describe how the EMA or TGA will utilize RWHAP Part A grant funds in support of a comprehensive continuum of high-quality care and treatment for people living with HIV/AIDS in the Part A service area.

- *NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion #1*
  The purpose of this section is to demonstrate the severity of the HIV/AIDS epidemic in the EMA/TGA, using quantifiable data on HIV epidemiology, co-morbidities, cost of care for Ryan White HIV/AIDS Program services, the service needs of emerging populations, Unmet Need for services, and unique service delivery challenges. This section should explain why supplemental funding for health services is needed to provide necessary services for PLWH in the EMA/TGA.

  ***Note**: When describing Need, applicants should **document the use of multiple data sets**, such as HIV/AIDS epidemiologic data, co-morbidity data, poverty and insurance status data, current utilization data, and assessments of emerging populations with special needs. All data sources must be cited.*

1. Jurisdictional Profile

When made available for funding, supplemental funds will be targeted to those eligible areas where epidemiologic data demonstrates that HIV disease prevalence rates are increasing, where there is documented Unmet Need, and where there is a demonstrated disproportionate impact on vulnerable populations.

(1) Use a table to describe the EMA/TGA incidence and prevalence of HIV and AIDS for the past 3 calendar years (2011, 2012, and 2013). Clearly cite the data sources.

(2) Use a table to provide HIV/AIDS cases by demographic characteristics (age, ethnicity, race, and gender) and exposure category in the EMA/TGA for the past 3 calendar years (2011, 2012, and 2013); if data for this 3 year period is unavailable, use data from the most current 3 year period and provide an explanation. Submit as **Attachment 3.**

(3) Provide a brief narrative description of the following:

a. Disproportionate impact of HIV/AIDS on specific populations within the EMA/TGA in comparison to the impact on the general population, including disproportionately impacted minority communities, homeless, and formerly-incarcerated individuals living with HIV/AIDS;

b. Populations of PLWH in the EMA/TGA that are under-represented in the Ryan White HIV/AIDS Program funded system of HIV/AIDS primary medical care; and

c. New/emerging populations not reported on in last year's application where significant changes were noted in service delivery in the EMA/TGA. Include information on how emerging populations were identified, unique challenges, service gaps, and estimated costs to the Part A Program, (if applicable).

2. Demonstrated Need

Supplemental awards are to be directed principally to those eligible areas with the greatest demonstrated need, based on documented factors that are comparable across the EMA/TGAs. In order to target funding to these areas, demonstrated need is given greater weight in the scoring process. The FY 2015 plan, budget, and allocations table should be consistent with the discussion of demonstrated need. The Demonstrated Need section includes: Unmet Need, Early Identification of Individuals with HIV/AIDS (EIIHA), Unique Service Delivery Challenges, Minority AIDS Initiative (MAI), and Impact of Funding.

A. Unmet Need

Unmet Need for Health Services, also referred to as Unmet Need, is the need for HIV related Health Services by individuals with HIV who are aware of their HIV status, but are not receiving regular primary health care.

(1) Provide an updated estimate of Unmet Need in your jurisdiction, using the HRSA/HAB Unmet Need Framework and calendar year (CY) 2013 data; include a copy of the framework in **Attachment 4** of this application.

(2) Provide a table showing the percentage of Unmet Need for PLWA and PLWH for CY 2011, 2012, and 2013. Based on this table, describe the trends in your Unmet Need percentages and to what you attribute these changes (e.g. increased outreach, increased linkages to care, increased number of low income PLWH).

(3) Describe how these Unmet Need trends are reflected in planning and decision making. Provide a narrative description of the following:

a. Determination of the demographics and location of people who know their HIV/AIDS status and who are not in care. Use geographic mapping such as zip code or geo-mapping data, if available.
b. Describe the method used to assess service needs, gaps, and barriers to care for people not in care; note the date of the latest needs assessment.
c. Describe efforts to assist the people who know their status and who are not in care in accessing primary care; specifically how the results of the Unmet Need Framework are reflected in the planning and decision making process about priorities, resource allocations, and the system of care. Examples include: (1) outreach activities, and (2) collaboration with other Ryan White and non-Ryan White HIV/AIDS Program funded providers.

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

The purpose of this section is to describe the strategy, plan, and data associated with ensuring that individuals who are unaware of their HIV status are identified, informed of their status, referred to supportive services, and linked to medical care if HIV positive. The goals of this initiative are to: 1) increase the number of individuals who are aware of their HIV status, 2) increase the number of HIV positive individuals who are in medical care, and 3) increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative.

Use of RWHAP funds for HIV testing:

RWHAP funds for testing under Early Invention Services (EIS) for Part A, Sections 2604(c)(3)(E) and 2604 (e)(1-2) of the PHS Act, can be used to include identification of individuals at points of entry and access to services and provision of:

a. HIV testing and targeted counseling;
b. Referral services;
c. Linkage to care; and
d. Health education and literacy training that enable clients to navigate the HIV system of care.

***Note:** All four EIS components must be present, but Part A funds to be used for HIV testing can be used only as necessary to supplement, not supplant existing funding for HIV testing, including routine testing, in the jurisdiction.*

(1) EIIHA Data

Select **three** (3) target populations in the previously submitted FY 2014 EIIHA Plan. For the selected three target populations, provide the following data for January 1, 2014 – June 30, 2014:

Newly diagnosed positive HIV test events:

a. Number of test events
   - *HIV testing event*

   An HIV testing event is a sequence of one or more HIV tests conducted with the client to determine his or her HIV status. During a single testing event, a client may be tested once (e.g., one rapid test or one conventional test) or multiple times (e.g., one rapid test followed by one conventional test to confirm a preliminary HIV-positive test result).

b. Number of newly diagnosed positive test events
   - *Newly identified HIV-positive result*

   An HIV-positive test result associated with a client who does not self-report having previously tested HIV positive and has not been reported to jurisdiction's surveillance department as being HIV positive.

c. Number of newly diagnosed positive test events with client linked to HIV medical care

- *Linkage to HIV medical care*

This calculated indicator determines whether a client with an HIV-positive test result was linked to HIV medical care within 90 days of initial positive test. In order for a client to be linked to care, the client must both be referred to HIV medical care and attend the first medical care appointment.

- *HIV medical care*

HIV medical care includes medical services for HIV infection including evaluation of immune system function and screening, treatment and prevention of opportunistic infections.

d. Number of newly diagnosed confirmed positive test events
   - *Newly identified confirmed HIV-positive result*

A confirmed HIV-positive test result associated with a client who does not self-report having previously tested HIV positive and who has not been reported to jurisdiction's surveillance department as being HIV positive.

- *Confirmed HIV-positive result*

A testing event with a positive test result for a conventional HIV test (positive EIA test confirmed by supplemental testing, e.g., Western Blot) or a nucleic acid amplification test (NAAT).

e. Number of newly diagnosed confirmed positive test events with client interviewed for partner services
   - *Referral to partner services*

This calculated indicator determines whether a client with a confirmed HIV-positive test result was given a referral to partner services.

- *Interviewed for partner services*

This calculated indictor determines whether a client with a confirmed HIV-positive test result was interviewed for partner services within 30 days of receiving a confirmed positive test result. In order for a client to be counted as interviewed for partner services, the client must both be referred to partner services and interviewed within 30 days of a positive test result.

f. Number of newly diagnosed confirmed positive test events with client referred to prevention services
   - *Referral to prevention services*

This indicator determines whether a client with confirmed HIV-positive test results was given a referral to HIV prevention services.

g. Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing
   - *CD4/VL*

This variable indicates whether a client with confirmed HIV-positive test results received CD4 and VL testing.

Previously diagnosed positive HIV test events:

a. Number of test events
   - *HIV testing event*

   An HIV testing event is a sequence of one or more HIV tests conducted with the client to determine his or her HIV status. During a single testing event, a client may be tested once (e.g., one rapid test or one conventional test) or multiple times (e.g., one rapid test followed by one conventional test to confirm a preliminary HIV-positive test result).

b. Number of previously diagnosed positive test events
   - *Previously identified HIV-positive result*

   An HIV-positive test result associated with a client who self-reports having previously tested HIV positive, or has been reported to jurisdiction's surveillance department as being HIV positive

c. Number of previously diagnosed positive test events with client re-engaged in HIV medical care
   - *Linkage to HIV medical care*

   This calculated indictor determines whether a client was linked to HIV medical care within 90 days of the re-diagnosis. In order for a client to be linked to care, the client must both be referred to HIV medical care and attend the first medical care appointment.

   - *HIV medical care*

   HIV medical care includes medical services for HIV infection including evaluation of immune system function and screening, treatment and prevention of opportunistic infections.

d. Number of previously diagnosed confirmed positive test events
   - *HIV testing event*

   An HIV testing event is a sequence of one or more HIV tests conducted with the client to determine his or her HIV status. During a single testing event, a client may be tested once (e.g., one rapid test or one conventional test) or multiple times (e.g., one rapid test followed by one conventional test to confirm a preliminary HIV-positive test result).

   - *Confirmed HIV-positive result*

   A testing event with a positive test result for a conventional HIV test (positive EIA test confirmed by supplemental testing, e.g., Western Blot) or a nucleic acid amplification test (NAAT).

e. Number of previously diagnosed confirmed positive test events with client interviewed for Partner Services
   - *Referral to partner services*

   This calculated indicator determines whether a client with a confirmed HIV-positive test result was given a referral to partner services.

- *Interviewed for partner services*

This calculated indictor determines whether a client with a confirmed HIV-positive test result was interviewed for Partner Services within 30 days of receiving their confirmed positive test result. In order for a client to be counted as interviewed for Partner Services, the client must both be referred to Partner Services and interviewed within 30 days of positive test result.

f. Number of previously diagnosed confirmed positive test events with client referred to prevention services

- *Referral to prevention services*

This indicator determines whether a client with confirmed HIV-positive test results was given a referral to HIV prevention services.

g. Number of previously diagnosed confirmed positive test events linked to and accessed CD4 cell count and viral load testing

- *CD4/VL*

This variable indicates whether a client with confirmed HIV-positive test results received CD4 and VL testing.

(2) **FY15 EIIHA Plan**

The overarching goal of the EIIHA Plan is to reduce the number of undiagnosed and late diagnosed individuals and to ensure they are accessing HIV care and treatment.

a. Describe the planned activities of the EMA/TGA EIIHA Plan for FY 2015. Include the following information:
   - An updated estimate of individuals who are HIV positive and who are unaware of their status, including the estimate methodology;
   - All populations for the EIIHA Plan;
   - The primary activities that will be undertaken, including system level interventions e.g. routine testing in clinical settings, expanding partner services;
   - Major collaborations with other programs and agencies, including HIV prevention- and surveillance programs; and
   - The planned outcomes of your overall EIIHA strategy.

b. Describe how the overall FY 2015 EIIHA Plan contributes to the goals of the National HIV/AIDS Strategy and the White House Continuum of Care Initiative. The Executive Order on the HIV Care Continuum Initiative that was released on July 15, 2013, is available at http://www.whitehouse.gov/the-press-office/2013/07/15/executive-order- hiv-care-continuum-initiative.

c. Describe how the Unmet Need estimate and activities related to the Unmet Need population inform and relate to the EIIHA planned activities.

d. Describe how the EIIHA Plan for FY 2014 (e.g. process, activities

and outcomes) influenced the development of the EIIHA Plan for FY 2015.

e. Describe any planned efforts to remove legal barriers, including state laws and regulations, to routine HIV testing.

f. Select three (3) distinct target populations for the FY 2015 EIIHA Plan. For each selected target population describe:
   - Why the target population was chosen and how the epidemiological data, Unmet Need estimate data, or other data supports that decision;
   - Specific challenges with or opportunities for working with the targeted population;
   - The specific activities that will be utilized with the target population;
   - Specific objectives for each component of EIIHA (identify, inform, refer, and link to care) for the target population (all objectives should be written as S.M.A.R.T. objectives – **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime phased);
   - The responsible parties, including any coordination with other agencies and/or programs for ensuring each of the activities are implemented, and their respective roles; and
   - Planned outcomes that will be achieved for the target population as a result of implementing the EIIHA Plan activities.

g. Describe plans to present, discuss, and/or disseminate the EIIHA Plan and outcomes of your EIIHA Plan activities to stakeholders (e.g. poster presentations, journal articles, presentations to planning bodies).

C. Unique Service Delivery Challenges

If applicable provide a brief narrative description of the need for HIV/AIDS emergency grant funds in the EMA/TGA based on factors not already discussed in the preceding demonstrated need narratives. The narrative should describe any unique service delivery challenges specific to the EMA/TGA Ryan White HIV/AIDS Program funded services, in terms of service costs, changes in service providers, and the complexity of providing care as a result of these challenges.

D. Minority AIDS Initiative

Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by the epidemic.

The purpose of the Part A MAI is to improve "HIV-related health outcomes to reduce existing racial and ethnic health disparities." As such, MAI funds provide direct financial assistance to Part A Grantees to develop or enhance access to high quality, community-based HIV/AIDS care services, and improve health outcomes for low-income minority individuals and families. For purposes of this FOA, 'minority' is defined as an individual who self-identifies as a member of one of the

racial/ethnic communities, including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders, or as 'more-than-one-race.' Any new/emerging minority populations, identified in the Jurisdictional Profile, should be targeted with MAI funds.

(1) Identify minority populations based on epidemiological data for your jurisdiction and the specific sub-groups (i.e. young African-American and Latino MSM; minority women receiving services at family planning clinics; substance users; and persons living with HIV who are leaving correctional facilities and re-entering communities; etc.) targeted with MAI funds.

(2) Describe how MAI funding was considered during the planning process and what service categories were funded to enhance access to services for disproportionately impacted minority populations and sub-groups; explain how these services differ from other Part A services.

(3) Briefly describe up to two (2) MAI funded activities used to serve minority sub-groups in an effort to reduce barriers and enhance the effectiveness of HIV services provided to specific minority populations. Describe the impact of these activities as they relate to the HIV continuum of care (i.e. linkage to care, retention in care and viral load suppression).

3. Impact of Funding

The purpose of this section is to describe the impact of Part A funding and how service and funding mechanisms are coordinated in the EMA/TGA.

A. Impact of the Affordable Care Act

Through the Affordable Care Act, insurance coverage options have been expanded for PLWH. These changes may affect insurance coverage options in the jurisdiction, as well as service needs and how those services are provided. In addition, these new options may require specific outreach and enrollment activities to ensure that people eligible for coverage are expeditiously enrolled in any coverage for which they may qualify.

(1) **Uninsured and poverty:** Provide, in a table format, data on PLWH who are uninsured and living in poverty. Include the following information as available:
   a. The number and percentage of persons who are enrolled in Medicaid, Medicare, and marketplace exchanges;
   b. The number and percentage of persons without insurance coverage; include those without Medicaid or Medicare; and
   c. The number and percentage of persons living at or below 138 percent and 400 percent of the 2014 FPL. Also include the percentage of FPL used to determine Ryan White eligibility in your jurisdiction.

(2) **Impact of insurance expansion:** Describe the impact of the Affordable Care Act and insurance expansion on the Part A RWHAP. Describe how the implementation of the Affordable Care Act impacts both service costs and the complexity of providing care to PLWH in the EMA/TGA. Describe any changes in service or allocations, including activities related to health insurance

premium assistance and cost sharing, either on a local level or in conjunction with the state.

(3) **Outreach and enrollment:** Describe efforts within the jurisdiction to conduct outreach to clients regarding insurance coverage options and to vigorously pursue enrollment of Part A clients into insurance coverage for which they may be eligible (e.g., Medicaid, private health insurance, etc.), as outlined in HAB Policy Clarification Notices 13-01 and 13-04 (http://hab.hrsa.gov/manageyourgrant/policiesletters.html). Describe coordination efforts with other agencies and community partners.

(4) **Marketplace options:** Provide an overall description of the plans available to PLWH and specify how they relate to the issue of provider accessibility and medications. Explain any challenges PLWH are experiencing or may experience in accessing care and medications.

(5) **Successes/Outcomes:** Please document any successes/case studies and/or outcomes in terms of cost-savings, service provision, and meaningful outcomes.

B. Impact and Response to Reduction in Ryan White HIV/AIDS Program Formula Funding

If the EMA/TGA experienced a reduction in Ryan White HIV/AIDS Program Part A Formula Funding last year, provide a narrative that addresses both the impact and response to the funding reduction, as follows:

(1) Impact: The specific services that were eliminated or reduced, and by how much; and

(2) Response: Any cost containment measures implemented, (e.g. waiting lists, client cost sharing, or other measures); planning council or community planning body response to the reduction in formula funding; and any transitional planning for clients receiving services that were either eliminated or reduced.

C. Impact of Co-morbidities on the Cost and Complexity of Providing Care

Ryan White HIV/AIDS Program funds are intended to supplement funding for local healthcare systems overburdened by the increasing cost of providing healthcare services. In addition to HIV/AIDS, public healthcare systems must address a variety of co-morbidities that may increase the cost of delivering care to persons living with HIV/AIDS. Caring for large numbers of PLWH clients with multiple diagnoses also adds to the cost and complexity of care.

(1) Present the profile of PLWH with co-morbidities in the EMA/TGA using quantitative evidence (in table format in **Attachment 5**) and document data sources. **The table must include:**

a. STI rates;
b. Prevalence of homelessness;
c. Formerly incarcerated;
d. Mental illness; and

e. Substance abuse

(2) Support the quantitative data presented in the table (**Attachment 5**), with a narrative description of the impact of co-morbidities, and co-factors on the cost and complexity of care in the EMA/TGA.

D. Coordination of Services and Funding Streams

Part A EMA/TGA planning efforts should expand the availability of services, reduce duplication of services, and bring newly diagnosed PLWH into care or engage PLWH who know their status, but are not presently in the HIV/AIDS care system. Planning should also be coordinated with all other public funding for HIV/AIDS to: (1) ensure that Ryan White HIV/AIDS Program funds are the payer of last resort, (2) maximize the number and accessibility of services available, and (3) reduce any duplication.

(1) Provide in table format as **Attachment 6,** a presentation of other public funding in the EMA/TGA. The table should include the dollar amount(s) and the percentage of the total available funds in 2014, and the anticipated funds in 2015 for the following:

a. Other Ryan White HIV/AIDS Program funding (Parts B, C, D, and F);
b. Federal/state and local sources of public funding; and
c. HIV/AIDS-related service funds available in FY 2014 and anticipated in FY 2015.

(2) Based on the table in **Attachment 6**, discuss how Part A funds are used to address any gaps in services within the jurisdiction.

- *METHODOLOGY -- Corresponds to Section V's Review Criterion #2*

1. Planning and Resource Allocation

The purpose of this section is to document the existence of a functioning planning process in the EMA/TGA that is consistent with Ryan White HIV/AIDS Program and HRSA/HAB Program requirements. Good planning is imperative for effective local and state decision making to develop systems of prevention and care that are responsive to the needs of persons at risk for HIV infection and people living with HIV. Activities to collaborate and/or develop a joint planning body are supported by both HRSA and CDC. Community involvement is an essential component for planning comprehensive, effective HIV prevention and care programs in the United States. Please refer to the joint HRSA/CDC letter dated February 24, 2014 for more information on integrated planning.

The composition of the planning council (PC) or planning body must reflect the demographics of the HIV/AIDS epidemic in the EMA/TGA. PC or planning body members must be trained regarding their legislatively mandated responsibilities and other competencies necessary for full participation in collaborative decision-making. As part of their ongoing training, planning councils are encouraged to educate members about service issues related to the prevention of domestic and sexual violence. Councils should also consider recruiting members who are knowledgeable about these issues.

A. Letter of Assurance from Planning Council Chair(s) or Letter of Concurrence from Planning Bodies

Provide a letter of assurance signed by the PC chair(s) or a letter of concurrence signed by planning body leadership as **Attachment 7**. The letter must address the following:

(1) That FY 2014 Formula, Supplemental, and MAI funds awarded to the EMA/TGA are being expended according to the priorities established by the PC or planning body;
(2) That all FY 2014 Conditions of Award relative to the PC or planning body have been addressed;
(3) That FY 2014 priorities were determined by the PC or planning body, and the approved process for establishing those priorities were used by the PC or planning body;
(4) That annual membership training took place, including the date(s); and
(5) That representation is reflective of the epidemic in the EMA/TGA. If there are any vacancies, provide a plan and timeline for addressing each vacancy. Note variations between the demographics of the non-aligned consumers and the HIV disease prevalence of the EMA/TGA.

B. Description of the Community Input Process

(1) Describe the over-all structure of your community input process; include a description of the priority setting and allocations process, an explanation of how planning is linked or may be linked in the future to health outcomes along the HIV Care Continuum.

(2) Describe the specific prioritization and allocation process and include the following:
   a. How the needs of the following were considered: persons not in care (Unmet Need), persons unaware of their HIV status (EIIHA); and historically underserved populations;
   b. How PLWH were involved in the planning and allocation processes and how their priorities were considered in the process;
   c. How data were used in the priority setting and allocation processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the EMA/TGA;
   d. How changes and trends in HIV/AIDS epidemiology data were used in the planning and allocation process;
   e. How cost data were used in making funding allocation decisions;
   f. How the community input process considered and addressed any funding increases or decreases in the Part A award;
   g. How MAI funding was considered during the planning process to enhance services to minority populations;
   h. How data from other federally funded HIV/AIDS programs were used in developing priorities **(Attachment 6)**;
   i. How anticipated changes, due to the Affordable Care Act, were considered in developing priorities;
   j. What efforts have or will be taken to integrate prevention and care planning at the Part A level.

C. Funding for Core Medical Services

Part A funds are subject to Section 2604(c) of the PHS Act which requires that grantees expend 75 percent of Part A funds on core medical services that are needed in the EMA/TGA for individuals with HIV/AIDS who are identified and eligible under the Ryan White HIV/AIDS Program.

All applicants are required to submit a table that lists planned services for FY 2015 that addresses the 75 percent core medical services allocation requirement, regardless of whether the applicant intends to apply for a Core Medical Services (CMS) Waiver. In addition, applicants must provide a table that is reflective of the results of the priority setting and resource allocation process, if those results are different from the table reflecting compliance with the 75 percent core medical services allocation requirement. For applicants who were granted a FY 15 CMS waiver prior to this application, submit the approved allocations table. (The Planned Services Table and the Core Medical Services Waiver request, if applicable, should be included as **Attachment 8.)**

- *WORK PLAN -- Corresponds to Section V's Review Criterion #2*

The purpose of this section is to provide a graphic depiction and narrative summary describing the EMA/TGA HIV Care Continuum during FY 2015. It should describe how Part A funded services are utilized to impact the HIV Care Continuum. The EMA/TGA system of HIV/AIDS care should be consistent with HRSA's goals of increasing access to services and decreasing HIV/AIDS health disparities among affected sub-populations and historically under-served communities. Consideration regarding how and to what extent the HIV Care Continuum has been or will be used will not be subject to scoring during objective review.

A. HIV Care Continuum for FY 2015

The Executive Order on the HIV Care Continuum Initiative that was released on July 15, 2013, is available at http://www.whitehouse.gov/the-press-office/2013/07/15/executive-order- hiv-care-continuum-initiative.

(1) Provide a graph which depicts RWHAP Part A HIV Care Continuum in the EMA/TGA. The HIV Care Continuum also referred to as the HIV Treatment Cascade is a model of the proportion of PLWHs who are engaged at each stage of HIV care - Diagnosed, Linked to Care, Retained in Care, Prescribed ART, and Virally Suppressed. The graph must include baseline data for calendar year 2013 or the most recent calendar year for each stage of the HIV Care Continuum. At a minimum programs should use their RSR data as a baseline to populate the continuum for Ryan White-eligible individuals. If programs have access to a greater pool of data, it is strongly encouraged that it be used in the continuum. Applicants must clearly explain their data set and what data sources are being utilized. To populate the beginning of the continuum, the Diagnosed and Linked to Care stages, at a minimum applicants should use their EIIHA data. This data may also be obtained from local or state prevention programs. Another source for the data is the CDC's *Data to Care: A Public Health Strategy Using HIV Surveillance Data to Support the HIV Care Continuum*. *Data to Care* is a toolkit designed to share information and

resources to assist health departments in developing and implementing a *Data to Care* program. The toolkit can be accessed at http://www.effectiveinterventions.org/en/HighImpactPrevention/PublicHealthStrategies/DatatoCare.aspx.

The definitions of the numerator and the denominator must be clearly stated for each stage. Applicants are strongly encouraged to use the same numerators and denominators as outlined for the HHS/HAB HIV Core Indicators. (http://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf ; http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html)

Include the five main stages of the HIV Care Continuum in the graph:

- **Diagnosed** - Number and percentage of people living with HIV/AIDS in the EMA/TGA diagnosed with HIV/AIDS.
- **Linked to Care** - Number and percentage of people living with HIV/AIDS in the EMA/TGA connected to an HIV healthcare provider.
- **Retained in Care** - Number and percentage of people living with HIV/AIDS in the EMA/TGA, receiving regular HIV medical care.
- **Prescribed Antiretroviral Therapy (ART)** - Number and percentage of people living with HIV/AIDS in the EMA/TGA, prescribed a combination of three or more antiretroviral drugs from at least two different HIV drug classes every day to control the virus.
- **Virally Suppressed** - Number and percentage of people living with HIV/AIDS in the EMA/TGA with a viral load below 200.

(2) The HIV Care Continuum depicted above illustrates the HIV epidemic for the EMA/ TGA. Utilizing the data from the graph, create a narrative which discusses the following:

a. How the HIV Care Continuum is currently or may be in the future utilized in planning, in prioritizing, in targeting and in monitoring available resources in response to needs of PLWH in the jurisdiction and in improving engagement at each stage in the continuum.

b. Current successes or possible improvements in supporting PLWH as they move from one stage in the continuum to the next.

c. Any gaps, barriers or unique challenges (i.e., data collection/ sharing, collaboration with other local, state and federal programs, etc.) that exist in developing and utilizing the HIV Care Continuum model in the Part A program. Describe how the Part A program addresses these gaps, barriers or unique challenges.

d. How will the FY 2015 award be used to address gaps/barriers and improve the HIV Care Continuum?

e. Any significant health disparities brought to light related to race, gender, sexual orientation and age among populations within your jurisdiction's HIV Care Continuum and activities targeted current or planned to

address these disparities.

B. FY 2015 Implementation Plan

The FY 2015 Implementation Plan demonstrates progress in impacting the HIV Care Continuum. The implementation plan is driven by stages of the HIV Care Continuum. The stages are consistent with the National HIV/AIDS Strategy goals. The implementation plan utilizes core medical and support service categories that are prioritized and funded by the planning council or through local community planning processes. The plan contains objectives and outcomes which are related to the Stages of the HIV Care Continuum, and demonstrate how funded services are implemented to achieve positive health outcomes and to promote access to high quality HIV care.

For additional information on the HHS seven common core indicators, refer
http://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf
http://blog.aids.gov/2012/08/secretary-sebelius-approves-indicators-for-monitoring-hhs-funded-hiv-services.html

The Implementation Plan is comprised of two main components:

(1) **RWHAP Implementation Plan: Service Category Table.**
The service category table illustrates how core medical and support services will be provided in the EMA/TGA. It is comprised of the service categories prioritized and funded by planning council or through local community planning processes. The objectives describe the specific end results that a service or program is expected to accomplish within a given time period and represent activities which have the greatest direct impact on the stages of the HIV Care Continuum. A service category may be related to more than one stage on the continuum. For example, Outpatient Ambulatory Medical Care impacts Linkage to Care, Retained in Care and Virally Suppressed.

a. List the EMA/TGA's **four** core medical service categories and **two** support service categories which comprise the largest amounts of Part A funding allocated on the FY 2015 Implementation Plan. For each of the core medical and support services listed, develop one or more time limited and measurable objectives. For MAI funds, list two service categories that comprise the largest amounts of MAI funding allocated for FY 2015 and use the same FY 2015 Implementation Plan format as for the Part A funding. For each objective, define the service unit, the number of persons to be served, the total number of service units to be delivered, and the estimated cost of meeting the objective.
b. These objectives will comprise one of two major elements of the FY 2015 Implementation Plan. Each service category should clearly provide a reference to the appropriate stage of the HIV Care Continuum and Outcome from the Ryan White Implementation Plan: HIV Care Continuum Table (see number 2. below)
c. The FY 2015 Implementation Plan should be placed in **Attachment 9** of the application.

(2) **RWHAP Implementation Plan: HIV Care Continuum Table (Attachment 9 continued)**

The RWHAP Implementation Plan: HIV Care Continuum Table tells the story of the Part A HIV Care Continuum in the jurisdiction. The table is comprised of the Stages of Change of the HIV Care Continuum, the Goal related to the stage, the Outcome related to the stage and a list of service categories utilized to achieve the goal related to the stage. The goal should be a broad statement that defines what will be accomplished and should state the impact on a stage of the HIV Care Continuum. The goal provides a framework for the objectives. A separate goal must be created for each stage of the HIV Care Continuum. Each stage also must have an outcome. The outcome must be one of the seven common core HHS indicators or one of the HAB Core performance measures related the stage of the HIV Care Continuum. The outcomes must include baseline data and establish a target. The baseline and target must be expressed as a numerator and denominator as well as the percent. The service categories related to the stage of the continuum are the final components of the table. This is a list of one or more service categories that will be funded to achieve the targets described in the outcome. The services categories should be those reflected in the Implementation Plan: Service Categories provided in number (1) above as well as all others that relate to the Stage of the HIV Care Continuum.

C. Implementation Plan Narrative

Based upon the FY 2015 Implementation Plan, provide a narrative that describes the following:

(1) Identify any prioritized core medical services that will not be funded with FY 2015 Ryan White HIV/AIDS Program funds and how these services will be delivered in the EMA/TGA; (e.g. services funded by Medicaid, Medicaid expansion, ACA marketplaces, SCHIP, etc.);

(2) How the activities described in the Plan will promote parity of HIV services throughout the EMA. Parity of services should be addressed in terms of geographic location of services, quality, comprehensiveness of services, and cultural appropriateness;

(3) How planned activities assure that services delivered by providers are culturally and linguistically appropriate to the populations served within the EMA/TGA;

(4) How the objectives, action items, and performance measures relate to the goals of Comprehensive Plan;

(5) How the EMA/TGA will ensure that resource allocations to provide services for WICY are in proportion to the percentage of EMA/TGA AIDS cases represented by each priority population; and

(6) How any recent EMA/TGA needs assessments or updates are linked or may be related to the HIV Care Continuum, including results of the EMA's/TGA's Unmet Need Framework and any new or different initiatives funded.

- *RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion #2*

Discuss challenges that have been or likely to be encountered in integrating the HIV Care Continuum into planning and implementing the Part A program, and approaches that will be used to resolve such challenges.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criterion #3*

1. Clinical Quality Management (CQM)

The Ryan White HIV/AIDS Program legislation requires that Part A Grantees "provide for the establishment of a CQM program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent PHS guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services". The legislation allows grantees to use the lesser of 5 percent of the amount of the grant or $3,000,000 for the activities associated with a CQM program, and states that CQM is not counted towards the administrative expense cap (Sec. 2604 (h)(5) of the PHS Act).

CQM data plays a critical role in documenting that services delivered to clients are improving their health status. Information gathered through the CQM program, as well as client-level health outcomes data, should be used as part of the EMA/TGA planning process and ongoing assessment of progress toward achieving program goals and objectives, including improving the HIV Continuum of Care. It should also be used by the grantee to examine and refine services based on outcomes and the cost of delivering quality care.

Note: HAB has a portfolio of performance measures that include clinical, systems, medical case management, oral health and the AIDS Drug Assistance Program. Grantees can select appropriate performance measures from HAB's portfolio to compose a "local" portfolio of performance measures. Grantees should select performance measures that are most important to their programs and the populations they serve, as they relate to their overall goals for improving clinical health outcomes. The "local" portfolio should include measures for all funded service categories. Grantees are strongly encouraged to incorporate HAB's core measures into their portfolio and add other measures as appropriate. HAB's performance measures, as well as frequently asked questions, can be found online at:
http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html

Links to the HHS HIV/AIDS guidelines (formerly called the Public Health Service Guidelines), the Ryan White HIV/AIDS Program legislation, and the resources and technical assistance (TA) available to grantees with respect to improving the quality of care, and establishing CQM programs may be found online at:
http://hab.hrsa.gov/manageyourgrant/granteebasics.html.

HAB's Part A Program Monitoring Standards (including the standards for Quality Management) can be found online at:
http://hab.hrsa.gov/manageyourgrant/files/programmonitoringparta.pdf.

A. Description of CQM Program Infrastructure:

(1) List the number of staff FTEs assigned to CQM.
(2) Describe the CQM program staff roles and responsibilities.
(3) Name the entity(s) under contract or to be contracted with for the CQM program, and activities the contractor has/will provide.

(4) Describe efforts to coordinate CQM activities with other Ryan White grantees in the jurisdiction.

B. Description of CQM Program Performance Measures:

(1) List the service categories for which the applicant has performance measures.
(2) List the performance measures for the upcoming year for outpatient/ambulatory medical care and medical case management. Describe the frequency of performance measure data collection from sub-grantees.
(3) Summarize the performance measure data collected for outpatient/ambulatory medical care and medical case management from the last grant year or calendar year, including any trending data.
(4) Describe how performance measure data are analyzed to evaluate for disparities in care and actions taken to eliminate disparities.
(5) Describe how stakeholders, including sub-grantees, consumers, and other Ryan White grantees in the jurisdiction and planning council/body contribute to the selection of performance measures and receive information about performance measure data.

C. Description of CQM Program Quality Improvement:

(1) Describe the processes for identifying priorities for quality improvement. Provide examples of specific quality improvement projects undertaken for outpatient/ambulatory medical care and medical case management. Describe the process to monitor and support sub-grantees' engagement in quality improvement projects.
(2) Describe efforts aimed at improving HIV viral suppression within the jurisdiction.
(3) Discuss how the CQM data have been used to improve and/or change service delivery in the EMA/TGA, including strategic long-range service delivery planning.
(4) Describe how stakeholders including sub-grantees, consumers, other Ryan White grantees in state, and planning council/body contribute to the selection of quality improvement activities undertaken by the applicant.

D. Data for Program Reporting

(1) Name and describe the information/ data system(s) within the EMA/TGA used for data collection and reporting operations.
(2) Describe the grantee's current client level data collection capabilities included in the Ryan White Service Report (RSR). Include the percentage of sub-grantees that were able to report CY 2013 client level data. Describe efforts to increase data completeness and validity.

- *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criteria #4 and 5*

1. Grantee Administration

The purpose of this section is to demonstrate the extent to which the chief elected official (CEO) or designee in the EMA/TGA has met the legislative requirements to disburse funds quickly, closely monitor their use, and ensure the Ryan White HIV/AIDS Program is the payer of last resort. The Ryan White HIV/AIDS Program

stresses the importance of timely obligation of Ryan White HIV/AIDS Program funds. Timely obligation of Ryan White HIV/AIDS Program funds ensures that services can be provided as rapidly as possible, and decreases the possibility that unobligated funds will remain at the end of the program year. Please refer to Section 2603(c) (1), (2) and (3) of the PHS Act regarding the Part A formula and supplemental unobligated balance (UOB) requirement. The UOB requirement does not apply to MAI funds.

Note: UOB Penalties
If unobligated balances of formula award exceed five percent, two penalties are imposed:

1. The future year award is reduced by the amount of UOB, less the amount of approved carryover; and
2. The grantee is not eligible for a future year supplemental award

Note, that like all other grantees with UOB, the amount of UOB not covered by a waiver for carryover is subject to an offset.

If the grantee reports unobligated formula funds of five percent or less, no penalties are imposed ,although a future year award will be subject to an offset.

Supplemental Funds
Under the Ryan White HIV/AIDS Program legislation, the HHS Secretary has flexibility regarding supplemental funds. Grantees may not submit a carryover request for supplemental funds, which would permit those funds to be added to the subsequent grant year; instead, UOB supplemental funds are subject to an offset. UOB supplemental funds do not make a grantee ineligible for a future year supplemental award.

A. Program Organization

(1) Provide a description of how Part A funds are administered within the EMA/TGA with reference to the staff positions, including program and fiscal staff, described in the budget narrative and the organizational chart provided in **Attachment 10**. The narrative should describe: the local agency responsible for the grant and identify the entity responsible for administering the Part A Program, including the department, unit, staffing levels (FTEs, including any vacancies), fiscal agents, PC/planning body staff, and in-kind support staff. Describe the approaches to fill vacant staff positions that are essential for delivery, oversight, and monitoring of the Part A and MAI services/activities.

(2) Provide a descriptive narrative of the process and mechanisms, including data collection to ensure that providers funded through multiple Ryan White HIV/AIDS Program Parts (i.e. Parts A, B, C, D, and F), will be able to distinguish which clients are served by each individual funding stream to avoid duplication of services.

B. Grantee Accountability

HRSA/HAB holds grantees accountable for the expenditure of funds awarded under Part A and expects grantees to monitor fiscal and programmatic compliance with all contracts and other agreements for HIV/AIDS services in the EMA/TGA. Grantees are also required to have on file a copy of each contractor's procurement document (contracts), and fiscal, program, and site visit reports.

(1) **Program Oversight** - Provide a narrative that describes the following:

a. An update on the grantee's implementation of the National Monitoring Standards;
b. The process used to conduct program monitoring;
c. The total number of contractors funded in FY 2014; the frequency of monitoring site visits (both programmatic and fiscal) and the generation of reports during a program year; the number and percentage of contractors that have received a fiscal and/or programmatic monitoring site visit to date, and the total number planned for the FY 2015 grant year;
d. The process and timeline for corrective actions when a fiscal or programmatic-related concern is identified; any improper charges or other findings in FY 2014 to date and a summary of the corrective actions planned or taken to address these findings;
e. The number of contractors that have received technical assistance (TA) for FY 2014, to date (types of TA, scope, and timeline).

(2) **Fiscal Oversight** - Provide a narrative that describes the following information:

a. The process used by program and fiscal staff to coordinate activities, ensuring adequate reporting, reconciliation, and tracking of program expenditures (i.e. meeting schedule, information sharing regarding contractor expenditures, UOB, and program income);
b. The process used to separately track formula, supplemental, MAI, and carry over funds, including information on the data systems utilized;
c. The process used to ensure timely monitoring and redistribution of unexpended funds;
d. The process for reviewing contractors compliance with the audit requirement in OMB Circular A-133;
e. If there were findings in any contractors' A-133 audit reports, describe what the grantee has done to ensure that contractors have taken appropriate corrective action. Corrective actions may include, but are not limited to, HRSA/HAB sponsored TA and training requests from the grantee of record; and
f. The process for reimbursing contractors, from the time a voucher/invoice is received to payment.

C. Third Party Reimbursement

The Ryan White HIV/AIDS Program is the payer of last resort, and grantees must make every effort to ensure that alternate sources of payments are pursued and that program income is used consistent with grant requirements. HRSA expects grantees to screen for proof of insurance status and financial eligibility for use of

funds on a regular basis (see http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf). Grantees are required to use effective strategies to coordinate between Part A and third party payers who are ultimately responsible for covering the cost of services provided to eligible or covered persons. Third party sources include Medicaid and any opportunities for expansion under the Affordable Care Act, Children's Health Insurance Programs (CHIP), Medicare, including Medicare Part D, and private insurance, including new options available under the health insurance marketplace established by the Affordable Care Act. Contractors providing Medicaid eligible services must be Medicaid certified.

(1) Provide a narrative that describes the following:

a. The process used by grantees to ensure that contractors are monitoring third party reimbursement; also describe the contract language or other mechanism to ensure that this takes place;
b. The process to conduct screening and eligibility to ensure the RWHAP is the payer of last resort; and
c. How the grantee monitors the appropriate tracking and use of any program income at both the grantee and contractor level.

D. Administrative Assessment

The Ryan White HIV/AIDS Program mandates that EMA/TGA PCs must assess the efficiency of the administrative mechanism to rapidly allocate funds to the areas of greatest need within the EMA/TGA.

(1) Provide a narrative that describes the results of the PC's assessment of the administrative mechanism in terms of:

a. Assessment of grantee activities to ensure timely allocation/contracting of funds and payments to contractors; and
b. If any deficiencies were identified by the PC, what were the deficiencies, what was the grantee's response to those deficiencies, and what is the current status of the grantee's corrective actions?

E. Maintenance of Effort (MOE)

The Ryan White HIV/AIDS Program legislation requires Part A Grantees to maintain, as a Condition of Award, EMA/TGA political subdivision expenditures for HIV-related core medical services and support services at a level equal to the 1-year period preceding the FY for which the grantee is applying to receive a Part A grant. After enactment of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Section 2604(b)(1) of the PHS Act states: "In general – The chief elected official of an eligible area shall use amounts from a grant under Section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services." Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the PHS Act and HAB's service definitions distributed to all grantees. Part A Grantees must document that they have met the MOE requirement.

To demonstrate that grantees understand this revision to the Part A MOE requirement, applicants must submit in this section the following information as. **Attachment 11**:

(1) A table that identifies the MOE budget elements and the amount of expenditures related to HIV/AIDS core medical and support services for FYs 2012 and 2013; and

(2) A description of the process used to determine the amount of expenditures in the table.

iii. Budget and Budget Justification Narrative

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) incurred by the recipient to carry out a grant-supported project or activity. Total project or program costs include costs charged to the award and costs borne by the recipient to satisfy a matching or cost-sharing requirement.

See Section 4.1.iv and v. of HRSA's *SF-424 Application Guide*. In addition, the Ryan White Part A HIV Emergency Relief Grant Program requires the following:

Complete Application Form SF-424A Budget Information – Non-Construction Programs provided with the application package. Please complete Sections A, B, and F.

Under Section B, Budget Categories, use the following column headings:

a. "Administrative"
b. "Clinical Quality Management"
c. "MAI"
d. "HIV Services"

Personnel and fringe benefits for program staff assigned to these budget categories should be placed on the appropriate line.

Provisions enacted in the Consolidated Appropriations Act, 2014 continue in 2015. The Consolidated Appropriations Act, 2014, Division H, § 203, (P.L. 113-76) states, "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.". Please see Section 4.1.iv Budget – Salary Limitation of HRSA's *SF-424 Application Guide* for additional information.

On the contractual services line-item list determine the amounts allocated for personnel or services contracted to outside providers for all HIV services. Show the amount allocated to any activities that are not conducted "in-house" on the Contractual line.

Grantee administration and planning council support or planning body support are all considered within the Grantee Administration budget, and together are capped at 10 percent. Grantees must determine the amounts necessary to cover all administrative and program support activities. The grantee must also ensure adequate funding for PC mandated functions within the administrative line item. "Planning Council support should cover *reasonable and necessary costs* associated with carrying out legislatively mandated functions."

In addition to the SF-424A, submit a budget narrative in table format **on the Budget Narrative Attachment form.** The budget narrative table should explain the amounts requested for each line in the budget by column headings listed, and explain how the line items listed support the overall Part A HIV service delivery system. The budget narrative table should clearly state how each object class category's efforts and/or activities make a contributing impact to support the Part A HIV service delivery system. Include a justification column that clearly explains the activities which impact the Part A HIV service delivery system. In addition, under the personnel object class category, all costs must include the name, position title, and FTE allotment.

Caps on expenses: Part A Grantee Administration Costs (including PC support) may **not** exceed 1 0 percent of the grant award. Administrative expenditures for first- line entities or sub-contractors may **not** exceed 10 percent of the aggregate amount allocated for services. **Reminder: Indirect costs are considered an administrative cost, which is capped at 10 percent of the grant award.** Grantees are allowed to allocate up to 5 percent of the total grant award or $3,000,000 (whichever is less), for CQM activities.

Administrative Costs are those costs associated with the administration of the Part A grant. By law, no more than 10 percent of the Part A budget can be spent on administrative costs. Sub-contractor administrative costs are capped at **10 percent in the aggregate.** Staff activities that are administrative in nature should be allocated to administrative costs. Examples of administrative costs at the grantee and sub-contractor level include:

- Indirect Costs, which are allowed only if the organization has a negotiated indirect cost rate approved by a cognizant federal agency. A copy of the latest negotiated cost agreement that covers the period for which funds are requested must be submitted as **Attachment 13** of the application (not counted in the page limit). Indirect costs are those costs incurred by the organization that are not readily identifiable, with a particular project or program, but are considered necessary to the operation of the organization and performance of its programs. All indirect costs are considered administrative for the Part A Program and, therefore, are subject to the 10 percent limitation on administrative expense.
- Operation and maintenance expenses including costs incurred for the administration, supervision, operation, maintenance, preservation, and protection of the grantee's and sub-contractors' physical facility; they include expenses normally incurred for such items as janitorial and utility services; repairs and ordinary or normal alterations of buildings, furniture and equipment; care of grounds; maintenance and operation of buildings and other facilities; security; earthquake and disaster preparedness; environmental safety; hazardous waste disposal; property, liability and all other insurance relating to property; space and capital leasing; facility planning and management; and central receiving.
- Rent, occupancy costs, utilities, and other facility support costs related to management of grant funds.
- PC support and related activities including assessment of the administrative mechanism.
- Personnel costs and fringe benefits of staff members responsible for the management of the grant.
- Costs associated with the grantee's contract award procedures including: development of requests for proposals (RFPs), drafting, negotiation, awarding, and

monitoring of contract awards.

- Costs associated with audits, payroll/accounting functions, medical coding and medical billing, human resources and recruitment.
- Costs associated with implementing national monitoring standards, including monitoring of sub-contractors.
- Telecommunications, including telephone, fax, pager and internet access.
- Postage.
- Office supplies.
- Computer hardware and software not directly related to patient care.
- Program evaluation, including data collection for evaluation.
- Office administrator, file clerk, clinic receptionist, and appointment reminder calls.
- Electronic health records, maintenance, licensure, annual updates, and data entry.
- Office equipment lease.
- Copying and printing.
- Program development and strategic planning.

Clinical Quality Management (CQM) Costs are those costs required to maintain a clinical quality management program to assess the extent to which services are consistent with the current HHS guidelines for the treatment of HIV/AIDS. Examples of clinical quality management costs include:

- Clinical Quality Management coordination;
- Continuous Quality Improvement (CQI) activities;
- Data collection for clinical quality management purposes (collect, aggregate, analyze, and report on measurement data);
- Grantee CQM staff training/ TA (including travel and registration) - this includes HRSA sponsored or HRSA approved training; and
- Training of sub-contractors

Minority AIDS Initiative (MAI) costs are intended to address the disproportionate impact that HIV/AIDS has on racial and ethnic minorities and to address the disparities in access, treatment, care, and outcomes for racial and ethnic minorities, including African-Americans, Alaska Natives, Hispanic/Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders.

HIV Services are **direct service** costs associated with the direct provision of Core Medical Services or Support Services. Staff positions such as medical assistants, dental hygienists, and nurses can be included in the budget when the position proportionately complements HIV primary medical care providers, such as physicians, dentists, physician assistants, or nurse practitioners being funded by the Part A Program. Some of the costs that are considered **direct services** under Core Medical Services include:

- Salaried personnel, contracted personnel or visit fees to provide core medical services directly to the HIV-infected client, including primary medical care, laboratory testing, oral health care, outpatient mental health, medical nutrition therapy, outpatient substance abuse treatment, specialty and subspecialty care. Provider time must be reasonable for the number of clients;
- Lab, x-ray, and other diagnostic tests;

- Medical/dental equipment and supplies; and
- Other clinical and diagnostic services regarding HIV/AIDS and periodic medical evaluations of individuals with HIV/AIDS, according to the DHHS guidelines. http://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0/
- Salaried or contracted personnel that provides outreach to and linkage to enrollment of RWHAP clients into health insurance coverage as a component of EIS. Referrals and linkages to care may include enrollment in Medicaid, Medicare, private insurance plans through the health insurance Marketplaces/Exchanges, and benefits counseling. Services are generally provided to clients who are new to care.
- Salaried or contracted personnel that provides outreach to and enrollment of RWHAP clients into health insurance coverage as a component of medical case management services; this may include benefits/entitlement counseling and referral activities to assist clients with access to other public and private programs for which they may be eligible (e.g., Medicaid, Marketplaces/Exchanges, Medicare Part D, State Pharmacy Assistance Programs, and other state or local health care and supportive services). Services are provided to prevent clients from falling out of care.

Support Services Costs are those costs for services which are needed for individuals living with HIV/AIDS to achieve optimal HIV medical outcomes. Some of the costs that are considered **direct services** under "support services" include:

- Salaried personnel, contracted personnel, or visit fees to provide support services directly to the HIV-infected or affected client;
- Salaried or contracted personnel that provides outreach to and enrollment of Ryan White HIV/AIDS Program (RWHAP) clients into health insurance coverage as a component of case management or referral for health and supportive services. This may include benefits/entitlement counseling and referral activities as allowable activities. Services that are provided to prevent clients from falling out of care. Referral for health and supportive services are generally provided to clients who have a change in insurance status, new eligibility, or require a change in treatment regimen;
- Salaried or contracted personnel that provide outreach to and enrollment of Ryan White HIV/AIDS Program (RWHAP) clients into health insurance coverage as a component of case management services; this may include benefits/entitlement counseling and referral activities as allowable activities. Services are provided to prevent clients from falling out of care;
- Peer to peer education/support;
- Patient navigators/community health worker aide; and
- Local travel by staff to provide support services.
- Under certain **limited circumstances**, rent may be an allowable direct service expense:
  - A food bank may charge rent as a direct service in some specific cases. For example - pantry where the food is stored or location where prepared bags of food may be picked up by the client. Grantee must work with a HRSA project officer to ensure the charge is *allowable.*
  - Residential substance abuse agencies may charge rent as a direct service for the rent of the residential facility for a specific timeframe.
  - Emergency financial assistance or housing services when Ryan White Part A

funds are used to cover all or a portion of a client's rent.

iv. Attachments

Please provide the following items in the order specified below to complete the content of the application. Unless otherwise noted, attachments count toward the application page limit. Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. **Each attachment must be clearly labeled.**

Attachment 1: Staffing Plan, Job Descriptions, and Biographical Sketches for Key Personnel (see section 4.1. of the HRSA's SF-424 Application Guide)

Attachment 2: Letters of Agreement, Memorandum of Understanding, Intergovernmental Agreements, FY 2014 Agreements and Compliance Assurances, Certifications
In addition to completing the SF-424B Assurances per instructions in the *SF-424 Application Guide*, also complete and submit the required Part A Grant Program FY 2015 Agreements and Compliance Assurances (see Appendix A), which should be submitted as part of **Attachment 2**

Attachment 3: HIV/AIDS Demographic Table

Attachment 4: Unmet Need Framework

Attachment 5: Co-morbidities, Cost and Complexity Table

Attachment 6: Coordination of Services and Funding Table

Attachment 7: Letter of Assurance from Planning Council Chair/Letter of Concurrence from Planning Body

Attachment 8: Planned Services Table, Core Medical Services Waiver Request (if applicable)

Attachment 9: FY 2015 Implementation Plan and HIV Care Continuum Table

Attachment 10: Organizational Chart

Attachment 11: Maintenance of Effort Documentation
Applicants must provide a baseline aggregate expenditure for the prior fiscal year (unless otherwise noted in statute), using a table that includes the item number, item description, agency/department unit, and related expenditures for FYs 2012 and 2013.

Attachment 12: Other Relevant Documents (Corrected from Budget Narrative Attachment)
Include here any other documents that are relevant to the application, including letters of support. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.) List all other support letters on one page. DO NOT ATTACH BUDGET NARRATIVE UNDER THIS ATTACHMENT.

Attachment 13: Federally Negotiated Indirect Cost Rate Agreement (if applicable, not counted in the page limit).

Attachments 14 – 15: Other Relevant Documents
Include here any other documents that are relevant to the application, including letters of support. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.) List all other support letters on one page.

3. Submission Dates and Times

Application Due Date
The due date for applications under this funding opportunity announcement is *September 19, 2014 at 11:59 P.M. Eastern Time.*

4. Intergovernmental Review

The Ryan White Part A Emergency Relief Grant Program is subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. See Executive Order 12372 in the HHS Grants Policy Statement.

See Section 4.1 ii of HRSA's *SF-424 Application Guide* for additional information.

5. Funding Restrictions

Applicants responding to this announcement may request funding for a project period of up to one (1) year.

Funds under this announcement may not be used for the following purposes:

- Construction is not allowable. Minor alterations and renovations to an existing facility, to make it more suitable for the purpose of the grant program are allowable with prior HRSA approval;
- Entertainment costs are not allowable; this includes the cost of amusements, social activities, and related incidental costs;
- Fundraising expenses are not allowable;
- Lobbying expenses are not allowable;
- International travel is not allowable;
- Pre-Exposure Prophylaxis (PrEP) or non-occupational Post-Exposure Prophylaxis (nPEP) – Ryan White HIV/AIDS Program funds cannot pay for PrEP or nPEP, as the person using PrEP or nPEP is not HIV infected, and therefore is not eligible for Ryan White HIV/AIDS Program funded medication; and
- Payment for any item or service to the extent that payment has been made (or reasonably can be expected to be made), with respect to that item or service, under any state compensation program, insurance policy, federal or state benefits program, or any entity that provides health services on a prepaid basis, (except for a program administered by or providing the services of the Indian Health Service).

Other non-allowable costs can be found in the appropriate OMB Circular, available at http://www.whitehouse.gov/omb/circulars/.

The General Provisions in Division H, Title V of the Consolidated Appropriations Act, 2014 (P.L. 113-76), apply to this program. Please see Section 4.1 of HRSA's *SF-424 Application Guide* for additional information. Note that these or other restrictions will apply in FY 2015, as required by law.

All program income generated as a result of awarded grant funds must be used for approved project-related activities.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

These criteria are the basis upon which the reviewers will evaluate the application. The entire proposal will be considered during objective review.

Review Criteria are used to review and rank applications. The Ryan White Part A Program has five review criteria:

Criterion 1: NEED (67 points) – Corresponds to Section IV's, ii, Project Narrative: Introduction, Needs Assessment/Jurisdictional Profile, Demonstrated Need, Impact of Funding and associated attachments. Note: This section includes EIIHA which is 33 points per legislation.

The extent to which the application demonstrates the problem and associated contributing factors to the problem.

1. **Jurisdictional Profile (7 points)**
   (1) HIV/AIDS Epidemiology Table is clear, complete, and consistent with the information in the narrative. The sources for all data are clearly identified.
   (2) HIV/AIDS Demographic Table (**Attachment 3**) is clear, complete, and consistent with the information in the narrative. The sources for all data are clearly identified.
   (3) The narrative description depicts the current HIV disease, as it relates to disproportionate impact on certain populations, under-represented populations, and new/emerging populations is clear and comprehensive.

2. **Demonstrated Need (48 points)**
   A. Unmet Need (7 points)

(1) The clarity and completeness of the applicant's Unmet Need framework estimates (using **Attachment 4)** which should include data sources and calculations.
(2) The table showing the percentage of Unmet Need for PLWA and PLWH is clear, complete, and consistent with the trends described in the narrative. The narrative clearly describes the trends in the Unmet Need percentages and what attributed to those trends.
(3) The applicant clearly describes how the Unmet Need populations are considered in planning and decision-making processes and how information is used to assist PLWA and PLWH in accessing primary medical care.

B. Early Identification of Individuals with HIV/AIDS (EIIHA 33pts)

***EIIHA Data* (14 pts)**

(1) For the selected three target populations, the extent to which the applicant provided the following complete data for January 1, 2014 – June 30, 2014:

Newly diagnosed positive HIV test events

a. Number of test events
b. Number of newly diagnosed positive test events
c. Number of newly diagnosed positive test events with client linked to HIV medical care
d. Number of newly diagnosed confirmed positive test events
e. Number of newly diagnosed confirmed positive test events with client interviewed for partner services
f. Number of newly diagnosed confirmed positive test events with client referred to prevention services
g. Total number of newly diagnosed clients with confirmed positive test events who received CD4 cell count and viral load testing.

Previously diagnosed positive HIV test events

a. Number of test events
b. Number of previously diagnosed positive test events
c. Number of previously diagnosed positive test events with a client re-engaged in HIV medical care
d. Number of previously diagnosed confirmed positive test events
e. Number of previously diagnosed confirmed positive test events with a client interviewed for partner services.
f. Number of previously diagnosed confirmed positive test events with client referred to prevention services
g. Number of previously diagnosed confirmed positive test events linked to and accessed CD4 cell count and viral load testing

***FY15 EIIHA Plan* (19 pts)**

(1) The extent to which the applicant described the planned activities of the EMA/TGA's EIIHA Plan for FY15:

a. Provided an updated estimate of individuals who are HIV positive and who are unaware of their status, including the estimate methodology;
b. Described all populations for the EIIHA Plan;
c. Described the primary activities that will be undertaken, including system level interventions e.g. routine testing in clinical settings, expanding partner services;

d. Identified major collaborations with other programs and agencies, including HIV prevention and surveillance programs; and
e. Described the planned outcomes of your overall EIIHA strategy.

(2) The extent to which the applicant described how the overall FY 2015 EIIHA Plan contributes to the goals of the National HIV/AIDS Strategy and the White House HIV Continuum of Care Initiative.

(3) The extent to which the applicant described how the Unmeet Need estimate and activities related to the Unmet Need population inform and relate to the EIIHA planned activities.

(4) The extent to which the applicant described how the EIIHA Plan for FY 2014 (e.g. process, activities and outcomes) influenced the development of the EIIHA Plan for FY 2015.

(5) The extent to which the applicant described any planned efforts to remove legal barriers, including State laws and regulations, to routine HIV testing.

(6) The applicant selected three (3) distinct target populations for the FY 2015 EIIHA Plan. For each selected target population a clear description was provided on:
a. Why the target population was chosen and how the epidemiological data, Unmet Need estimate data, or other data supports that decision;
b. Specific challenges with or opportunities for working with the targeted population;
c. Specific activities that will be utilized with the target population;
d. Specific objectives for each component of EIIHA (identify, inform, refer, and link to care) for the target population (all objectives should be written as S.M.A.R.T objectives – **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime phased);
e. The responsible parties, including any coordination with other agencies and/or programs for ensuring each of the activities are implemented, and their respective roles;
f. Planned outcomes that will be achieved for the target population as a result of implementing the EIIHA Plan activities.

(7) The extent to which the applicant described plans to present, discuss, and/or disseminate the EIIHA Plan, and outcomes of EIIHA Plan activities to stakeholders e.g. poster presentations, journal articles, presentations to planning bodies.

C. Unique Service Delivery Challenges (2 points)

(1) If applicable, the applicant provided a compelling narrative description of the need for HIV/AIDS emergency grant funds in the EMA/TGA, based on factors not already discussed. The narrative describes the unique service delivery challenges in terms of service costs, changes in service providers, and the complexity of

providing care.

D. Minority AIDS Initiative (6 points)

(1) The extent to which the applicant clearly identified minority populations based on data presented in the epidemiology table, narrative on new/emerging populations, if applicable (FOA page 8), and specific sub-groups targeted with MAI funds.

(2) The extent to which activities described are clearly linked to the planning process and service delivery categories under MAI.

(3) The extent to which the applicant clearly described two activities that will reduce barriers and enhance effectiveness of HIV services provided to specific minority populations and its impact on the HIV Continuum of Care.

3. Impact of Funding (12 points)

A. Impact of the Affordable Care Act (4 points)

(1) The extent to which the applicant provided a table with available data on PLWH who are uninsured and living in poverty in their jurisdiction.

(2) The extent to which the applicant provided a narrative based on available information on the impact of insurance expansion, outreach and enrollment, marketplace options, and successes and outcomes.

B. Impact of Co-morbidities on Cost and Complexity of Providing Care (4 points)

(1) The strength of the narrative description, based on the table in **Attachment 5** of the impact of co-morbidities and co-factors on the cost and complexity of care in the EMA/TGA.

C. Coordination of Services and Funding Streams (4 points)

(1) The clarity and completeness of the table "Coordination of Services and Funding Streams" **(Attachment 6)** in describing the availability of other public funding in the EMA/TGA. The quality of the table to include both the dollar amount(s) and the percentage of the total available funds in 2014, and the anticipated funds in 2015 for the following:

a. other Ryan White HIV/AIDS Program funding (Parts B, C, D, and F);
b. federal/state and local sources of public funding; and
c. HIV/AIDS-related service funds available in FY 2014 and anticipated in FY 2015.

Criterion 2: RESPONSE (15 points) – Corresponds to Section IV's, ii, Project Narrative: Methodology/Planning and Resource Allocation, Work Plan/HIV Continuum of Care and FY 2015 Implementation Plan, Resolution of Challenges and associated attachments

The extent to which the proposed project responds to the "Purpose" included in the program description. The strength of the proposed goals and objectives and their relationship to the identified project. The extent to which the activities (scientific or other) described in the application are capable of addressing the problem and attaining the project objectives.

1. Planning and Resource Allocation (6 pts.)

A. The Letter of Assurance or Concurrence signed by the PC chair(s) or planning body leadership fully addressed the following components (1 point):

(1) The FY 2014 formula, supplemental, and MAI funds awarded to the

EMA/TGA are being expended according to the priorities established by the PC;

(2) That all FY 2014 Conditions of Award relative to the PC have been addressed;

(3) The FY 2014 priorities were determined by the PC, and the approved process for establishing those priorities was used by the PC;

(4) Date of annual membership training took place; and

(5) Representation is reflective of the epidemic; if there are vacancies, a plan and timeline to address each vacancy; if applicable, noted variations between demographics of non-aligned consumers and HIV disease prevalence of the EMA or TGA.

B. Description of the Community Input Process (3 points)

(1) The extent to which the applicant clearly documents the existence of a functioning planning process in the EMA or TGA that describes community input, priority setting, and allocations processes.

(2) The extent to which the applicant provides a clear description of how the prioritization and allocation process addresses the data and information presented in the Need section of the application.

(3) The extent to which the applicant provides a clear description of how data from various sources (i.e. epidemiology data, cost data, federally funded HIV/AIDS programs etc.) were used in the planning and allocation process.

(4) The extent to which the applicant provides a description of how PLWH were involved and how their priorities were considered in the planning and allocation process.

(5) The extent to which the applicant provided a clear description of how MAI funding was considered during the planning process.

(6) The extent to which the applicant clearly described how anticipated changes due to the Affordable Care Act were considered in developing priorities.

C. Funding for Core Medical Services (2 points)

Submission of a table that lists all the planned services for FY 2015 and addresses the 75 percent core medical services allocation requirement. The Planned Services Table and the Core Medical Services Waiver request, (if applicable) should be included as **Attachment 8.**

2. HIV Care Continuum and FY 2015 Implementation Plan (8 pts)

A. HIV Care Continuum (2 points)

(1) The clarity and completeness of the description of the HIV Care Continuum, including a graph depicting the data presented; assess how well these match the gaps identified in the Need section.

B. FY 2015 Implementation Plan (6 points)

(1) The clarity and completeness of the FY 2015 Implementation Plan that includes all the stages of the continuum, goals, outcomes and service categories. **Note: The HIV Care Continuum Table should not be scored.**

(2) The completeness of the Plan for each service category related to the HIV Care Continuum. The objectives to be funded and how they are clearly linked to a specific stage(s) of the HIV Care Continuum:

- A service unit definition that clearly and consistently measures the objective (e.g. a one-hour face-to-face encounter, one round-trip bus ride, one primary care visit);
- The number of people who will be served;
- The total number of service units that will be provided; and
- The estimated cost (funded by Part A and/or by MAI) for meeting each objective during the time periods.

(3) The comprehensiveness and strength of the narrative that supports the FY 2015 Implementation Plan. The extent to which the narrative expands and clarifies the information presented in the Plan and describes the following:

- Prioritized core medical services that will not be funded with FY 2015 Ryan White HIV/AIDS Program funds and how these services will be delivered in the EMA/TGA; (e.g. services funded by Medicaid, Medicaid expansion, Affordable Care Act marketplaces, SCHIP, etc.)
- How the activities described in the Plan will promote parity of HIV services throughout the EMA. Parity of services should be addressed in terms of geographic location of services, quality, comprehensiveness of services, and cultural appropriateness;
- How planned activities assure that services delivered by providers are culturally and linguistically appropriate to the populations served within the EMA/TGA;
- How the objectives, action items, and performance measures relate to goals of the Comprehensive Plan;
- How the EMA/TGA will ensure that resource allocations to provide services for WICY are in proportion to the percentage of EMA/TGA AIDS cases represented by each priority population; and
- How any recent EMA/TGA needs assessments or updates (including results of the EMA's/TGA's Unmet Need framework) are linked with the HIV Care Continuum.

2. <u>Resolution of Challenges (1 point)</u>

The applicant clearly discusses challenges that have or likely to be encountered in integrating the HIV Care Continuum into planning and implementing the Part A program and approaches that were or will be used to resolve such challenges.

Criterion 3: EVALUATIVE MEASURES (5 points) – Corresponds to Section IV's, ii, Project Narrative: Evaluation and Technical Support Capacity/CQM

1. <u>Clinical Quality Management (CQM) (5 points)</u>

(1) Infrastructure: The extent to which the applicant provided a clear description of the CQM Program staff, FTEs, roles, responsibilities, contracted staff and activities undertaken by contractor, and coordination of activities with other Ryan White grantees in jurisdiction.

(2) Performance measurement: The extent to which the applicant provided a detailed list the service categories for which the applicant has performance measures; clearly described specific performance measures that are monitored by outpatient/ambulatory medical care and medical case management service categories and frequency at which performance measure data are collected from subgrantees; and summarized performance measure data including trends for outpatient/ambulatory medical care and medical case management; and clearly described how performance measure data are analyzed to evaluate for disparities in care and actions taken to eliminate disparities;

(3) Quality Improvement: The extent to which the applicant clearly described the processes for identifying priorities for quality improvement, examples of specific quality improvement projects undertaken for outpatient/ambulatory medical care and medical case management, and clearly described the process to monitor and support subgrantees engagement in quality improvement projects; and clearly described efforts aimed at improving HIV viral suppression within the jurisdiction.

Criterion 4: RESOURCES/CAPABILITIES (10 points) – Corresponds to Section IV's, ii, Project Narrative: Organizational Information/Grantee Administration and associated attachments

1. Grantee Administration

A. <u>Program Organization (2 points)</u>

(1) The extent to which the applicant provided a narrative that described the following:

a. A clear and complete description of the local agency responsible for the grant and identifies the entity responsible for administering the Part A Program. Included should be the department, unit, staffing levels (FTEs, including any vacancies), fiscal and/or management agents, planning and evaluation bodies, and in-kind support staff;

b. A viable process and mechanisms, including data collection used to ensure providers funded through multiple Ryan White HIV/AIDS Program Parts (i.e. Parts A, B, C, D, and F) distinguish which clients are served by each individual funding stream to avoid duplication of services;

B. <u>Grantee Accountability (8 points)</u>

Program Oversight

(1) The applicant provides a narrative that describes the following:

a. The strength and feasibility of the steps taken by the EMA/TGA in 2014 to implement the National Monitoring Standards;

b. The frequency of fiscal and programmatic monitoring site visits during a program year, and the process and timelines for corrective actions when a fiscal or programmatic-related concern is identified; and

c. Any improper charges or other findings in FY 2014, to date, and a summary of the corrective actions planned or taken to address these findings, as well as the number of contractors that received TA in FY 2014, to date (types, scope, and timeline of TA).

Fiscal Oversight
The applicant provides clear documentation and description of the following:

(1) A comprehensive description of the process used by program and fiscal staff to coordinate activities ensuring adequate reporting, reconciliation, and tracking of program expenditures.

(2) A clear description of the process used to separately track formula, supplemental, MAI, and carry over funds, including information on the data systems utilized, and the process used to ensure timely monitoring and redistribution of funds.

(3) A detailed description of a coordinated process for reviewing contractor compliance with the audit requirement in OMB Circular A-133; and, if there were findings in any sub-contractors' A-133 audit reports; what the grantee has done to ensure that sub-contractors have taken appropriate corrective action.

(4) A detailed description of the process for reimbursing contractors/sub-contractors, from the time a voucher/invoice is received to a payment being made.

Criterion 5: SUPPORT REQUESTED (3 points) – Corresponds to Section IV's, ii, Project Narrative: Organizational Information, MOE, Budget and associated attachments

The reasonableness of the proposed budget in relation to the objectives, the complexity of the activities, and the anticipated results.

Budget and Maintenance of Effort (MOE) Documentation
(1) The reasonableness and completeness of the SF 424A, with the required categories.

(2) The clarity and strength of the budget justification, with descriptions that explain the amounts requested for each line in the budget as it relates to the needs described in the Need section.

(3) The clarity and completeness of the documentation describing how the EMA/TGA met the MOE legislative requirement, as supported by the MOE Table, included with the application. A clear and thorough description of the process for identifying and tracking core medical services, and support services budget elements used to calculate the MOE.

2. Review and Selection Process

Please see section 5.3 of the HRSA's *SF-424 Application Guide*.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of March 1, 2015.

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of March 1, 2015. See Section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2 of HRSA's *SF-424 Application Guide*.

Implementation of United States v. Windsor and Federal Recognition of Same-sex Spouses/Marriages

The following policy applies to:

- all grants except block grants governed by 45 CFR part 96, part 98, and grant awards made under titles IV -A, XIX and XXI of the Social Security Act.
- programs which base eligibility or otherwise make distinctions in program participation or content on such terms as "marriage," "spouse," "family," "household member," or similar references to familial relationship.

A standard term and condition of award will be included in the final Notice of Award (NOA) that states: "In any grant-supported activity in which family, marital, or household considerations are, by statute or regulation, relevant for purposes of determining beneficiary eligibility or participation, grantees must treat same-sex spouses, marriages, and households on the same terms as opposite-sex spouses, marriages, and households, respectively. By "same-sex spouses," HHS means individuals of the same sex who have entered into marriages that are valid in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "same-sex marriages," HHS means marriages between two individuals validly entered into in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "marriage," HHS does not mean registered domestic partnerships, civil unions or similar formal relationships recognized under the law of the jurisdiction of celebration as something other than a marriage."

3. Reporting

The successful applicant under this funding opportunity announcement must comply with Section 6 of HRSA's *SF-424 Application Guide* and the following reporting and review activities:

1) **Progress Report**(s). The awardee must submit a progress report to HRSA on an annual basis. Further information will be provided in the award notice.

2) **Program Terms Report.** The awardee must submit a program terms report to HRSA ninety (90) days after the award is made; further information will be provided in the notice of award.

3) **MAI Annual Plan and Report.** The awardee must submit an annual plan on the proposed services provided with MAI funds, as well as an annual report on the outcomes of the services provided; further information will be provided in the notice of award.

4) **Expenditure Table.** The awardee must submit a table on Part A and MAI expenditures; further information will be provided in the notice of award.

5) **Ryan White Services Report.** Acceptance of this award indicates the grantee assures it will comply with data requirements of the Ryan White Services Report (RSR) and that it will mandate compliance by each of its contractors and sub-contractors. The RSR captures information necessary to demonstrate program performance and accountability.

6) **Client level Data Report.** All Ryan White HIV/AIDS Program core services and support services providers are required to submit client level data for CY 2014. Please refer to the HIV/AIDS Program Client Level Data website at http://hab.hrsa.gov/manageyourgrant/techdataassistance.html for additional information.

7) **Waiver to Request Carryover.** The Ryan White HIV/AIDS Program legislation requires a waiver to request carryover of unobligated formula funds before the end of the grant year. A carryover waiver application, together with the estimated unobligated balance (UOB), must be submitted to HRSA/HAB, stating the purpose for which such funds will be expended during the carryover year, no later than December 31, (with an automatic extension to the first workday following December 31, if it is a weekend or holiday).

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Karen Mayo, Grants Management Specialist
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 18-75
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-3555
Fax: (301) 594-4073
Email: KMayo@hrsa.gov

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting:

Steven R. Young, MSPH
Director, Division of Metropolitan HIV/AIDS Programs
Attn: Funding Program
HIV/AIDS Bureau, HRSA
Parklawn Building, Room 9W12
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-9091
Fax: (301) 443-5271
Email: SYoung@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding Federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
E-mail: support@grants.gov
iPortal: https://grants-portal.psc.gov/Welcome.aspx?pt=Grants

Successful applicants/awardees may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Call Center, Monday-Friday, 9:00 a.m. to 5:30 p.m. ET:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
E-mail: CallCenter@HRSA.GOV

VIII. Other Information

All applicants are encouraged to participate in a technical assistance (TA) webinar for this funding opportunity. The technical assistance webinar is tentatively scheduled for August 7, 2014 from 2-4PM Eastern Time. The purpose of this webinar is to assist potential applicants in preparing applications that address the requirements of this funding announcement. Participation in a pre-application TA webinar is optional.

Dial-in Phone Number: 1-800-857-6259
Passcode: 7527379
To access the webinar online, go to the Adobe Connect URL:
https://hrsa.connectsolutions.com/2015FOA/

IX. Tips for Writing a Strong Application

See Section 4.7 of HRSA's *SF-424 Application Guide*.

Appendix A

FY 2015 AGREEMENTS AND COMPLIANCE ASSURANCES
Ryan White HIV/AIDS Program
Part-A Grant Program

I, the Chief Elected Official of the Eligible Metropolitan Area or Transitional Grant Area Marcellina A. Ogbu, (hereinafter referred to as the EMA/TGA) assure that:

Pursuant to Section 2602(a)(2) 1, 2
The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

Pursuant to Section 2602(a)(2)(B)
The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last 5 years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

Pursuant to Section 2602(b)(4)
The EMA/TGA Planning Council will determine the size and demographics of the population of individuals with HIV/AIDS, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status; determine the needs of such population, and develop a comprehensive plan for the organization and delivery of health and support services. The plan must include a strategy with discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of their HIV status, and enabling such individuals to use the health and support services. The strategy should particularly address disparities in access and services among affected subpopulations and historically underserved communities.

Pursuant to Section 2603(c)
The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)
The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council.

Pursuant to Section 2604(a)
The EMA/TGA will expend funds according to priorities established by the Planning Council, and for core medical services, support services, and administrative expenses only.

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[1] All statutory references are to the Public Health Service Act, unless otherwise specified.
[2] The six new TGAs (Baton Rouge, Columbus, Charlotte, Indianapolis, Memphis, and Nashville) are exempted from these requirements, but must provide a process for obtaining community input as described in **Section 2609(d)(1)(A)**.

Section 2604(c)

The EMA/TGA will expend not less than 75 percent of service dollars for core medical services, unless waived by the Secretary.

Pursuant to Section 2604(f)
The EMA/TGA will, for each of such populations in the eligible area use, from the grants made for the area under Section 2601(a) for a FY, expend not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS, unless a waiver from this provision is obtained.

Pursuant to Section 2604(g)
The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary.

Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)
The EMA/TGA will expend no more than 10 percent of the grant on administrative costs, and in accordance with the legislative definition of administrative activities and the allocation of funds to entities and subcontractors, will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

Pursuant to Section 2604(h)(5)
The EMA/TGA will establish a CQM Program that meets HRSA requirements and that funding for this program shall not exceed the lesser of 5 percent of program funds or $3 million.

Pursuant to Section 2604(i)
The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)
With regard to the use of funds,

a. funds received under Part A of Title XXVI of the PHS Act will be used to supplement, not supplant, state funds made available in the year for which the grant is awarded to provide HIV related services to individuals with HIV disease;
b. during the grant period, political subdivisions within the EMA/TGA will maintain at least their prior FY's level of expenditures for HIV related services for individuals with HIV disease;
c. political subdivisions within the EMA/TGA will not use funds received under Part A in maintaining the level of expenditures for HIV related services as required in the above paragraph; and
d. documentation of this MOE will be retained.

Pursuant to Section 2605(a)(3)
The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the healthcare system for the purpose of facilitating EIS for individuals diagnosed as being HIV positive.

Pursuant to Section 2605(a)(5)
The EMA/TGA will participate in an established HIV community based continuum of care, if such continuum exists within the EMA/TGA.

Pursuant to Section 2605(a)(6)
Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any state compensation program, insurance policy, or any Federal or state health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

Pursuant to Section 2605(a)(7)(A)
Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

Pursuant to Section 2605(a)(7)(B)
Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

Pursuant to Section 2605(a)(7)(C)
A program of outreach services will be provided to low-income individuals with HIV disease to inform them of such services.

Pursuant to Section 2605(a)(8)
The EMA/TGA has participated in the Statewide Coordinated Statement of Need (SCSN) process initiated by the state, and the services provided under the EMA/TGA's comprehensive plan are consistent with the SCSN.

Pursuant to Section 2605(a)(9)
The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

Pursuant to Section 2605(a)(10)
The EMA/TGA will submit audits every 2 years to the lead state agency under Part B of Title XXVI of the PHS Act.

Pursuant to Section 2605(e)
The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

Pursuant to Section 2681(d)
Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

Pursuant to Section 2684
No funds shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

_____ Date_____

Signature

Print Form

Introduction Form

By a Member of the Board of Supervisors or the Mayor

Time stamp
or meeting date

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

☒ 1. For reference to Committee. (An Ordinance, Resolution, Motion, or Charter Amendment)

☐ 2. Request for next printed agenda Without Reference to Committee.

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

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

☐ 5. City Attorney request.

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

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

☐ 8. Substitute Legislation File No. [ ]

☐ 9. Reactivate File No. [ ]

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

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

☐ Small Business Commission ☐ Youth Commission ☐ Ethics Commission

☐ Planning Commission ☐ Building Inspection Commission

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

Sponsor(s):

Supervisor Scott Wiener

Subject:

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

The text is listed below or attached:

Resolution authorizing the San Francisco Department of Public Health to submit an application to continue to receive funding for the Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A) grant from the Health Resources Services Administration, requesting $36,118,233 in HIV emergency relief program funding for the San Francisco Eligible Metropolitan Area for the period of March 1, 2015, through February 28, 2016.

Signature of Sponsoring Supervisor: Scott Wiener

For Clerk's Use Only:

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