APPROACHING ZERO IN A TIME OF CRISIS:
SAN FRANCISCO EMA FY 2022 RYAN WHITE PART A
COMPETING CONTINUATION APPLICATION NARRATIVE

▪ INTRODUCTION

The San Francisco Eligible Metropolitan Area (EMA) requests a total **$15,590,728** in Fiscal Year 2022 Ryan White Part A Formula and Supplemental funding to continue to respond to the ongoing local crisis of HIV infection; maintain and enhance the local comprehensive model continuum of HIV care; and develop and implement innovative, effective, and collaborative models for identifying, linking, and retaining persons in HIV care. In alignment with both local and national HIV goals and initiatives, and with coordinated integration with both new and emerging funding streams, our programmatic mission is to achieve the maximum possible level of viral load suppression across all locally impacted populations and neighborhoods, with the primary goal of **making the San Francisco EMA the first metropolitan region in the United States to effectively eliminate new infections and halt HIV disease progression**. Requested Part A funding will ensure an integrated, comprehensive, and culturally competent system of care focused on reducing inequities and disparities in HIV care access and outcomes while working toward full health justice and equity in regard to accessing prevention, medical care, and support services for all residents in the region. The FY 2022 Part A Service Plan described in this application supports an integrated continuum of intensive health and supportive services for complex, severe need, and multiply diagnosed populations which are structured to support and further self-management through personal empowerment of persons living with HIV (PLWH), despite the impacts and challenges of the COVID-19 pandemic. The Plan also highlights the San Francisco EMA's continually expanding integration of HIV care services with HIV, hepatitis, and sexually transmitted infection (STI) outreach, testing, linkage, and care retention services, while incorporating the perspectives and input of consumers, providers, and planners from across the region. The FY 2022 Part A application presents an effective strategy to preserve and advance a tradition of HIV service excellence in the San Francisco EMA while continuing to serve as a **national model** for eliminating new HIV infections through regional viral suppression.

▪ NEEDS ASSESSMENT

A. Demonstrated Need

1. Epidemiologic Overview

Overview of the Geographic Region: Located along the western edge of the San Francisco Bay in Northern California, the San Francisco Eligible Metropolitan Area (EMA) is a unique, diverse, and highly complex region. Encompassing three contiguous counties - **Marin County** to the north, **San Francisco County** in the center and **San Mateo County** to the south - the EMA has a total land area of **1,016** square miles, an area roughly the size of Rhode Island. In geographic terms, the EMA is very narrow, stretching more than 75 miles from its northern to

southern end, but less than 20 miles at its widest point from east to west. This complicates transportation and service access in the region, especially for those in Marin and San Mateo Counties. In San Mateo County, the Santa Cruz mountain range marks the western boundary of the San Andreas Fault bisects the region from north to south, creating challenges for those attempting to move between the county's eastern and western sides. The San Francisco (SF) EMA is also unusual because of the dramatic difference in the size of its member counties. While Marin and San Mateo Counties have a land area of **520** and **449** square miles, respectively, San Francisco County has a land area of only **46.7** square miles, making it **by far the smallest county in California** geographically, and the **sixth smallest county in the US** in terms of land area. San Francisco is also one of only three major cities in the US (the others are Denver and Washington, DC) in which the city's borders are identical to those of the county in which it is located. The unification of city and county governments under a single mayor and Board of Supervisors allows for a streamlined service planning and delivery process.

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

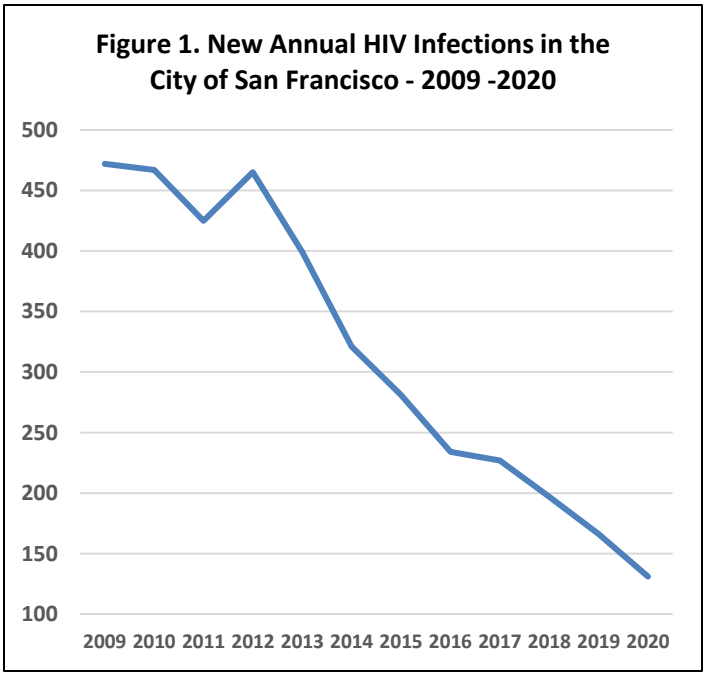
The geographic diversity of the San Francisco EMA mirrors the diversity of the people who call the area home. Nearly three out of every five of the EMA's residents (**59.1%**) are persons of color, including Asian/Pacific Islanders (**29.8%**), Latinxs (**18.9%**), and Black / African Americans (**4.1%**).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

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

b. <u>Socioeconomic Characteristics of Persons Affected by HIV:</u>

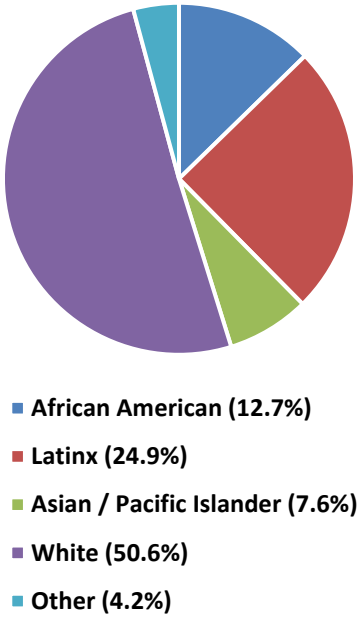
i. <u>Demographic Data:</u> More than 35 years into the HIV epidemic, the three counties of the San Francisco region continue to be severely impacted by HIV – an ongoing crisis that has exacted an enormous human and financial toll on our region. As of December 31, 2020, well over **42,000** cumulative cases of HIV had been diagnosed in the region, and over **25,000** persons have died as a result of the local HIV epidemic. As of the end of 2020, a total of **14,666** known, HIV-aware persons were currently living with HIV in the region's three counties, representing **10.1%** of Californians living with HIV (n=137,785 as of 12/31/19) and **1.2%** of all persons living with HIV in the US (n=1,189,700 as of 12/31/19).[2] The SF EMA's region-wide HIV infection rate of **769.1** cases per 100,000 persons also means that roughly **1 in every 130 residents of the San Francisco region is now living with HIV.** This figure of 14,666 living HIV cases represents the most up-to-date data provided from the State of California, and is based strictly on the number of persons living with HIV who have a **current address** in the San Francisco EMA. Several thousand more living cases of HIV have been diagnosed in the San Francisco EMA, but are not included in our proposal in order to be as accurate as possible regarding the current state of local HIV care needs. Additionally, many persons travel to the City of San Francisco to seek HIV care each month, but are also not included in our estimate of the local HIV care burden.

At the epicenter of the continuing HIV crisis lies the City and County of San Francisco, the city hardest-hit during the initial years of the AIDS epidemic and an area still hugely impacted by HIV**.** Today, the City of San Francisco continues to have the nation's highest per capita prevalence of cumulative AIDS cases,[3] and HIV remains a leading cause of death in the city among all age groups, as it has been for nearly two decades.[4] As of the end of 2020, a total of **12,242** San Franciscans were living with diagnosed HIV infection who had a **confirmed current address** in the city, representing **83.5%** of all persons living with HIV in the three-county region, for a staggering citywide prevalence of **1,376.5 cases of HIV per 100,000.** At the same, the CDC reports a total of **15,811** persons who had received a diagnosis of HIV while living in the city as of the end of 2020, resulting in a per capita HIV incidence of **1,777.8 per 100,000.**



In 2018, the City of San Francisco recently achieved an important milestone: for the first time since the start of the epidemic, fewer than 200 new HIV cases were diagnosed in the city (n=**197**), a figure that was surpassed in 2019 with only **166** new HIV cases reported. **This year, the number has fallen even lower, to a total of only 131 new HIV cases identified in 2020.** This represents a decrease of **57.7%** from the **227** new

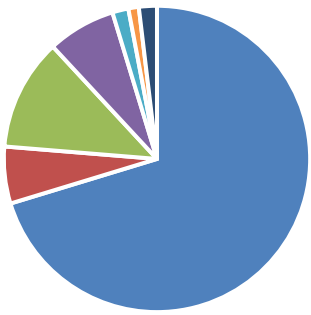
Figure 2. Persons Living with HIV in the San Francisco EMA by Ethnicity as of December 31, 2020



HIV cases diagnosed in 2017 and a startling **360.3% reduction** from the **472** new HIV cases diagnosed in the city in 2009. The record-breaking decline in new HIV diagnoses speaks to the city's integrated, systemwide strategy resulting from its plan to become the first city in the nation to achieve a goal of zero new HIV infections.

Race / Ethnicity: Reflecting the ethnic diversity of our region, the local HIV caseload is distributed among a wide range of ethnic groups. Because the local HIV epidemic had its first broad impact on white men who have sex with men (MSM), the slight majority of persons living with HIV continue to be white (**50.6%**). Another **12.7%** of cases are among Black / African Americans; **24.9%** are among Latinx individuals; and **7.6%** are among Asian / Pacific Islanders (see **Figure 2**). A total of **7,250** persons of color were living with HIV infection in the three-county region as of December 31, 2020, representing **49.3%** of all persons living with HIV. Black / African Americans are significantly over-represented in terms of HIV infection, making up **12.7%** of all persons living with HIV while comprising only **4.1%** of the area's population. This disproportion is even greater among **women** with HIV, a group in which Black / African American women make up **37.2%** of all PLWH while comprising **4.0%** of the region's total female population. Additionally, among the region's hard-hit transgender population, persons of color make up **82.1%** of all trans PLWH, including a population that is **31.4%** Black / African American, **35.8%** Latina, and **10.2%** Asian / Pacific Islander.

Figure 3. Persons Living with HIV in San Francisco EMA by Transmission Category as of December 31, 2020

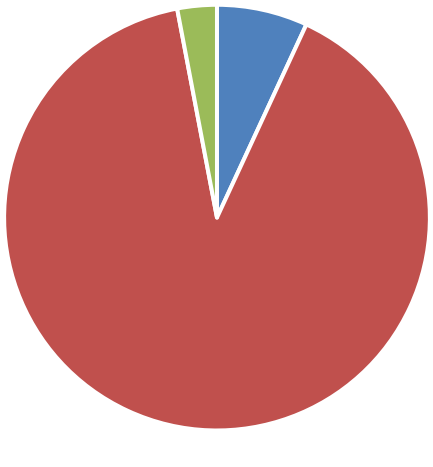


Transmission Categories: The most important distinguishing characteristic of the HIV epidemic in the San Francisco region is that HIV remains primarily a

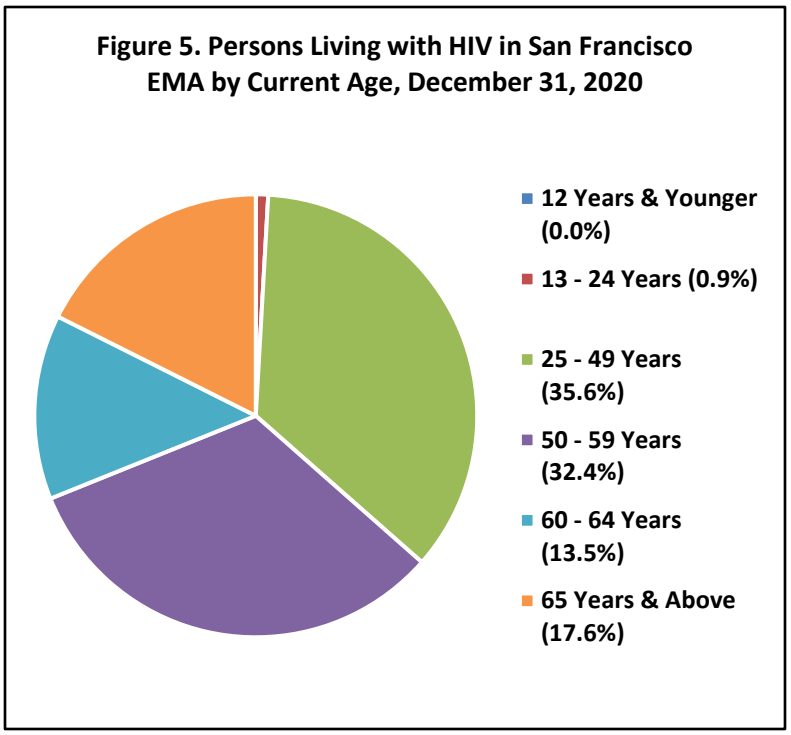
disease of men who have sex with men (MSM). In other regions of the US, the proportionate impact of HIV on MSM has declined over time as populations such as women, injection drug users, and heterosexual men have been increasingly affected by the epidemic. While these groups have been impacted in our region as well, their representation as a proportion of total PLWH has remained relatively low. Through December 31, 2020, fully **82.7%** of persons living with HIV in our region were MSM (**12,451**), including **10,657** men infected with HIV through MSM contact only (**70.8%** of all PLWH) and **1,794** MSM who also injected drugs (**11.9%** of all PLWH) (see **Figure 3**). This actually represents a slight increase from a decade ago, in 2008, when MSM made up **82.3%** of all PLWH. By comparison, only **44.5%** of all PLWH in New York City as of June 30, 2019 were listed as infected through MSM contact – roughly **half** the MSM infection burden of the San Francisco EMA.[5] Factors underlying this difference include the high proportion of gay and bisexual men living in the region; the large number of local long-term MSM HIV survivors; growing rates of STD infection among MSM, resulting in large part from expanding PrEP use; and relatively high local drug use rates, including an ongoing methamphetamine use crisis. Other significant local transmission categories include heterosexual persons who inject drugs (PWID) (**6.3%** of PLWH) and non-PIWD heterosexuals (**6.8%**). **The proportion of heterosexual HIV cases in the San Francisco EMA is believed to be the lowest of any EMA in the US.** Additionally, **1.7%** of all PLWH in the San Francisco EMA are transgender women who have sex with men (WSM) while another **1.1%** are transgender WSM who inject drugs.

Gender: Reflecting the high prevalence of HIV among men who have sex with men, the vast majority of persons living with HIV in the San Francisco region (**90.1%**) are cis men (see **Figure 4**). Only **6.9%** of PLWH in the region are cis women, over **71%** of whom are women of color. Among Black / African Americans living with HIV, fully **15.2%** are women. **The three-county San Francisco region has historically contained what is by far the lowest percentage of women, infants, children, and youth (WICY) living with HIV of any region or jurisdiction in the nation.** By contrast, because of their high representation within the San Francisco population, **transgender persons** also make up a significant percentage of PLWH, with at least **440** transgender individuals - the vast majority of them male-to-female – living with HIV as of December 31, 2020, representing **2.6%** of the region's PLWH caseload. It is believed that many transgender persons move to San Francisco seeking a more tolerant environment, increased social support, and greater access to culturally responsive trans health and social services.

Figure 4. Persons Living with HIV in San Francisco EMA by Gender as of December 31, 2020



Current Age: The vast and growing majority of persons living with HIV in the San Francisco region are age 50 and



above. This is attributable to the long history of the epidemic in our region - resulting in a large proportion of long-term survivors - and to the region's hard-fought success in bringing persons with HIV into care and maintaining their health over time. As of December 31, 2020, **nearly 2 out of every 3** persons living with HIV in the SF EMA (**63.5%**) is age 50 or older, including **5,752** PLWH between the ages of 50 and 59; **1,984** PLWH between the ages of 60 and 64; and **2,580** PLWH who are age 65 or older (see **Figure 5**). In the city of San Francisco alone, persons 50 and older make up **70.9%** of all persons living with HIV. Between December 2009 and December 2020, the number of persons 50 and over living with HIV increased by **44.8%** within the region while the number of PLWH 65 and older increased by **91.2% over the last 48 months alone**. **Figure 6** on the following page provides a demographic overview of the 50 and older HIV population as of the end of 2019 - a population that includes **601** women, **180** transgender persons, and over **1,000** men and women with HIV age 70 or higher, including **117** PLWH age 80 or above. This growing aging population creates significant challenges for the local HIV service system, including the need to coordinate and integrate HIV and geriatric care and to plan for long-term impacts of HIV drug therapies.

In terms of other age groups, persons between the ages of 25 and 49 make up **35.6%** of all PLWH in the region (n=**5,226**) while young adults ages 13 - 24 make up **less than 1.0%** of all PLWH in the region (n=**122**). However, young people ages 13 - 24 made up **12.0%** of all new HIV cases identified in calendar year 2020 (n=**16**), pointing to a continued growing HIV incidence within this population, although the overall number of new infections in the region continues to decrease. The population of young PLWH also includes a significantly higher percentage of **persons of color**, who make up **82.5%** of young people with HIV ages 13 - 24 while making up **48.1%** of the overall PLWH population. The same is true for **cis women**, who make up **16.1%** of youth PLWH as compared to only **6.7%** of all PLWH in the EMA. Only **2** children aged 12 or under are living with HIV in the region, and **no** new HIV cases have been diagnosed among this group since 2005.

ii) Socioeconomic Data:

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

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

Poverty: The problem of poverty presents a daunting challenge to the HIV care system. According to the US Census, the average percentage of persons living at or below federal poverty level stands at **12.6%** for the entire San Francisco region. Using this data, SF DPH projects that at least **720,826** individuals in the San Francisco region are living at or below 300% of Federal Poverty Level for a family of three (**$65,160**). This translates to at least **37.8%** of the EMA's population lacking resources to cover all but the most basic expenses. **However, at the time of this writing, this percentage is believed to be much higher and growing rapidly as a result of the severe economic impacts of the COVID-19 pandemic.** Additionally, because of the high cost of living in the San Francisco Bay Area, persons at 300% of poverty or below have a much more difficult time surviving in our area than those living at these income levels in other parts of the U.S. Analyzing 2020–2021 data from the San Francisco AIDS Regional Information and Evaluation System (ARIES), the SF region's client-level data system, it is estimated that at least **58.4%** of all persons living with HIV in the San Francisco region (n=**8,575**) are living at or below 300% of the 2020 Federal Poverty Level (FPL) including persons in impoverished households, while **98.6%** of Part A-funded clients live at or below 400% of poverty.[6] ARIES data from 2020-2021 also reveals that **68.5%** of active Ryan White Part A clients in the San Francisco region are currently living at or below 138% of FPL while another **21.8%** are living between 139% and 250% of FPL. HIV-infected persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **$352 million** in Part A and non-Part A HIV-related expenditures in the San Francisco region each year[7].

The problem of poverty is greatly amplified by the **growing disparity between rich and poor in San Francisco** which has become a critical issue over the past decade as a continuing influx of young professionals from the Silicon Valley to the south has prompted rapid gentrification and the upheaval of many formerly low and middle-income neighborhoods. According to the Brookings Institution, the San Francisco metropolitan area has the **3rd highest level** of household income inequality of any region in the US in (after Bridgeport, CT and New York, NY) while the City of San Francisco itself has the **5th highest level** of income inequality of all cities in the US.[8] The Public Policy Institute of California reports that San Francisco Bay Area has the widest level of income disparity of any region in the state, with residents in the 90th percentile of incomes earned **$384,000** per year as compared to **$32,000** for those in the bottom 10th percentile, meaning that the richest Bay Area residents earned more than **10 times** that of its poorest residents. [9]

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

Figure 7.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs, 2021

County	Hourly Wage to Rent a 2-Bdrm. Apt. at HUD Fair Market Rents
San Francisco County, CA	$ 68.33
Marin County, CA	$ 68.33
San Mateo County, CA	$ 68.33
Santa Clara County, CA	$ 58.67
Santa Cruz County, CA	$ 58.10
Alameda County, CA	$ 45.83
Contra Costa County, CA	$ 45.83
Santa Barbara County, CA	$ 45.65
Orange County, CA	$ 44.83
San Diego County, CA	$ 40.85

Because of the prohibitively high cost of housing in the San Francisco region and the shortage of affordable rental units, the problem of homelessness has reached crisis proportions, creating formidable challenges for organizations seeking to serve HIV-infected populations. According to the National Low Income Housing Coalition's *Out of Reach 2020* report, **Marin, San Francisco, and San Mateo Counties – the three counties that make up the San Francisco region – are tied with one another as the three least affordable counties in the nation** in terms of the minimum hourly wage needed to rent an average two-bedroom apartment, which currently stands at **$68.33 per hour** (see **Figure 7**).[11] This means that an individual must make more than $68 an hour to afford a 2-bedroom apartment, and represents an increase of **nearly 45% in the last 48 months alone**. Meanwhile, according to the 2021 HUD Fair Market Rent Documentation System, San Francisco has the **highest HUD-established Fair Market Rental rate in the nation** at **$2,350** for a studio apartment and **$3,553** for a 2-bedroom apartment, which represents the amount needed to "pay the gross rent of privately owned, decent, and safe rental housing of a modest nature".[12]

Cover of Annual Out of Reach Report Featuring San Francisco Civic Center

At the same time, despite aggressive efforts that had shown progress, San Francisco saw a **16.8% jump** in the number of homeless residents over the past two years, from **6,858** homeless persons in 2017 to **8,011** homeless persons in 2019, according to the most recent Point in Time Homeless Count, even as youth and veteran homelessness decreased by **10.1%** and **14.3%**, respectively.[13] This trend is reflective of other homelessness increases in major cities across the nation. Additionally, more than **59%** of single parents in SF also live below the **California Self-Sufficiency Standard (SSS)**, a measure that incorporates the cost of basic needs for California's working families.[14] An analysis of 2020-2021 ARIES data revealed that **less than 70%** of Ryan White Part A clients were stably housed during the year (**68.1%**), with **22.3%** living in temporary housing and **5.5%** living in unstable housing, including in shelters and on the street.

Insurance Coverage: The advent of health care reform through the Affordable Care Act (ACA) has resulted in significant, positive change in regard to the number and proportion of low-income persons with HIV in our region who benefit from affordable and more accessible health insurance coverage. According to the Public Policy Institute of California, approximately **93.0%** of Californians now have some form of health insurance, up from **82.5%** in 2013.[15] However, this still means that about **2.8 million** Californians lacked health insurance in 2018, with approximately **two-thirds** (**65%**) of those insured being Latinx persons.[16] Nevertheless, significant insurance gaps remain in our region. Analysis of local ARIES data revealed that **29.4%** of all persons enrolled in Ryan White Part A services in the three-county region during the 2020-2021 fiscal year were uninsured at some point during the year, including persons without Medicaid or Medicare.

Additionally, significant **disparities** exist in regard to type of health insurance coverage among newly diagnosed persons with HIV. For example, while **72%** of whites and **74%** of Black / African Americans newly diagnosed with HIV in 2020 had insurance at the time of diagnosis, only **64%** of Latinx and **61%** of Asian / Pacific Islanders had health insurance at the time of diagnosis.[17] Additionally, the **type** of insurance varied greatly among populations. For example, while **41%** of whites had private insurance at the time of HIV diagnosis in 2020 - up from **29%** in 2016 - only **11%** of Black / African Americans and **16%** of Latinx persons had private insurance at diagnosis. Conversely, while **43%** of whites, **48%** of Black / African Americans, and **49%** of

Latinx persons had some form of public insurance at the time of diagnosis, only **27%** of Asian / Pacific Islanders had public insurance at the time of initial HIV diagnosis.[18]

The issue of persons **losing their private disability insurance** is growing in importance as the population of PLWH 50 years and older increases and as these individuals are more likely to rely on private disability insurance than their younger counterparts. In October of 2014, the San Francisco Board of Supervisors, Budget and Legislative Analyst Office released a Policy Analysis Report on PLWH who age off Long Term Disability Insurance. The report reviewed data from several sources to estimate the number of PLWH who have private disability insurance and will reach retirement age and Social Security eligibility in the next 15 years. The report found that over **1,200** PLWH over 50 years old rely on private disability insurance, which terminates at age 65. The overall effect of the drop in income that will occur as people lose their private disability insurance is difficult to predict conclusively. However, evidence does suggest that for many PLWH, the lost income would make it impossible to afford San Francisco's current median rent.

Burden of HIV in the Service Area: It is important to note that the City of San Francisco continues to have the **largest per capita concentration of persons living with HIV of any metropolitan region in the United States.** As noted above, as of the end of 2020, a total of **12,242** San Franciscans were living with diagnosed HIV, representing **83.5%** of all persons living with HIV in the EMA. **This means that 1 in every 73 San Francisco residents is now living with HIV disease - an astonishing concentration of HIV infection in a city with just under 890,000 residents.** The incidence of **1,376.5** persons living with HIV per 100,000 in San Francisco County is **three times** that of Los Angeles County in Southern California (**459.8** per 100,000).[19]

c. New HIV Infections:

i. Trends in New HIV Infections: As a result of the SF EMA's integrated and comprehensive collaborative efforts to expand HIV awareness and testing and link and retain persons with HIV in care, new HIV infections in our region continue to decline across all age groups, while the disparities gap for new infections among Black / African Americans and Latinx populations is also beginning to close. The total of **211** new cases of HIV infection diagnosed in the SF EMA in calendar year 2020 is the fewest number of regional new infections in the history of the HIV epidemic, while the **131** new HIV cases diagnosed in the city of San Francisco represents a **42.3%** reduction from the **227** new HIV cases diagnosed in 2017 and a **72.3% reduction** from the **472** new HIV cases diagnosed in the city in 2009. Between 2011 and 2020, the number of newly identified HIV infections among whites in San Francisco declined by **83.3%**, from **222** to **37** new cases, while the number of newly identified cases among Black / African Americans declined by **57.8%,** from **64** in 2011 to **27** in 2020. The number of new HIV diagnoses among Latinx individuals in SF also dropped from **86** in 2011 to **49** in 2020, a reduction of **43.0%**. Per capita rates of new HIV diagnoses among SF women also dropped over the past decade, with new HIV diagnoses among Black / African American women dropping from **65** new infections 2011 to **22** infections in 2020. Similarly, new HIV infections among Latinx women decreased from **15** new infections in 2011 to only **5** new HIV infections in 2020.

Despite these heartening reductions, however, it is critical to note that **communities of color** continue to have by far the highest incidence of new HIV infections in the San Francisco EMA, and that rates of new infections among these groups continue to outpace their

representation in the overall PLWH population. Rates of new HIV infection in the San Francisco EMA in 2020 stood at **23.03** per 100,000 among Black / African Americans and **23.32** per 100,000 among Latinx persons, as compared to a rate of only **7.54** per 100,000 among whites. And while **24.9%** of all PLWH in the EMA as of the end of 2020 were Latinx, fully **39.8%** of all new EMA HIV diagnoses in 2020 occurred within this population. At the same time, while Asian / Pacific Islanders made up **7.6%** of all PLWH at the end of 2020, they accounted for **12.3%** of all new 2020 HIV diagnoses. Similar increases are also occurring among **women**, who made up **6.9%** of all PLWH at the end of 2020 but comprised **10.4%** of all new HIV diagnoses in 2020. Similar increases occurred among **transgender persons**, who accounted for **3.0%** of all PLWH at the end of 2020 but **4.3%** of all new HIV cases identified in 2020. Alarmingly, while young people between the ages of 13 and 24 make up only **0.9%** of PLWH in the EMA, they made up **13.8%** of all new HIV diagnoses in 2020.

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

- Overall, **94%** of people living with HIV in San Francisco are estimated to be **aware of their infection.**
- In 2020, **95%** of persons newly diagnosed with HIV in San Francisco were linked to care within **one month** of diagnosis.
- In 2020, **77%** of newly diagnosed persons with HIV in San Francisco achieved viral suppression **within six months** of diagnosis and fully **78%** of persons newly diagnosed with HIV achieved viral suppression **within six months** of diagnosis while **84%** achieved viral suppression within 12 months of diagnosis.
- In 2020, only **6.6%** of new HIV diagnoses were among **persons who inject drugs (PWID)** due to the success of extensive syringe access programs in San Francisco.

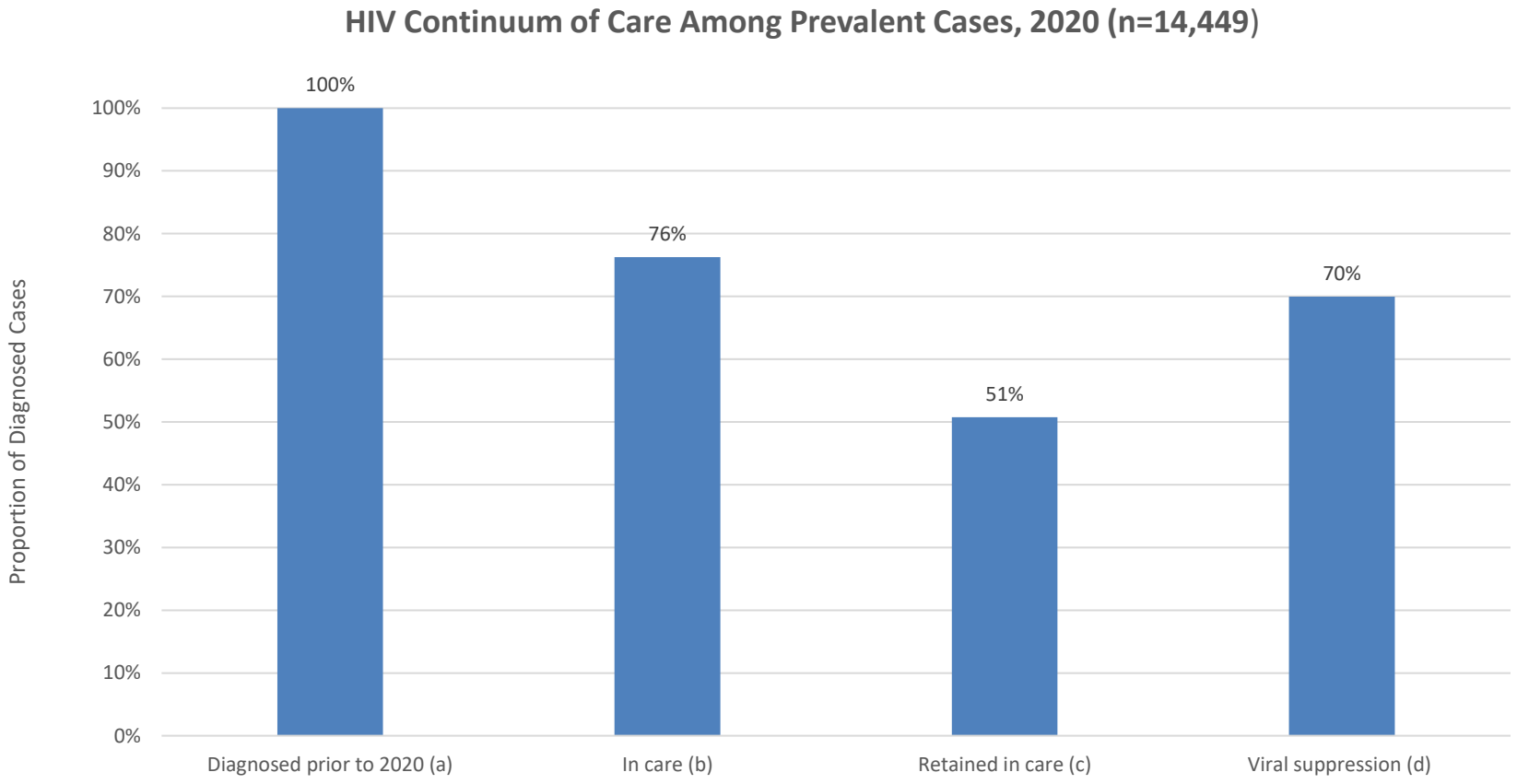
ii. <u>Increasing Need for HIV Services:</u> While the successes of the San Francisco approach to HIV prevention, identification, and care are both significant and heartening, it is critical to note that a large share of the model's success is attributable to the **significant federal resources** for both prevention and care, including efforts to more rapidly identify and link persons with HIV to care and to retain them in care and on medication regimens on a long-term basis. This includes expanded Medicaid reimbursement through ACA and the continuing support for HIV care through Ryan White Part A and other programs, which enable persons with HIV to achieve long-term viral suppression and reduce the rate of new HIV infections in our region. At the same

time, the total number of persons living with HIV in the EMA continues to grow, and the increasing number of persons 50 and older with HIV puts additional demands on the system to meet more complex HIV-related aging needs of long-term survivors. To sustain the success of the San Francisco approach to eliminating HIV, and to allow the region to continue to serve as a national laboratory for HIV case reductions, these federal resources will continue to be of the utmost importance. Any reduction in federal support for health, HIV, and related services has the potential to rapidly undo the progress we have made and back to coping with a public health emergency in which funds are inadequate to stop a new surge of HIV infection and HIV-related morbidity and mortality.

2. <u>HIV Care Continuum</u>

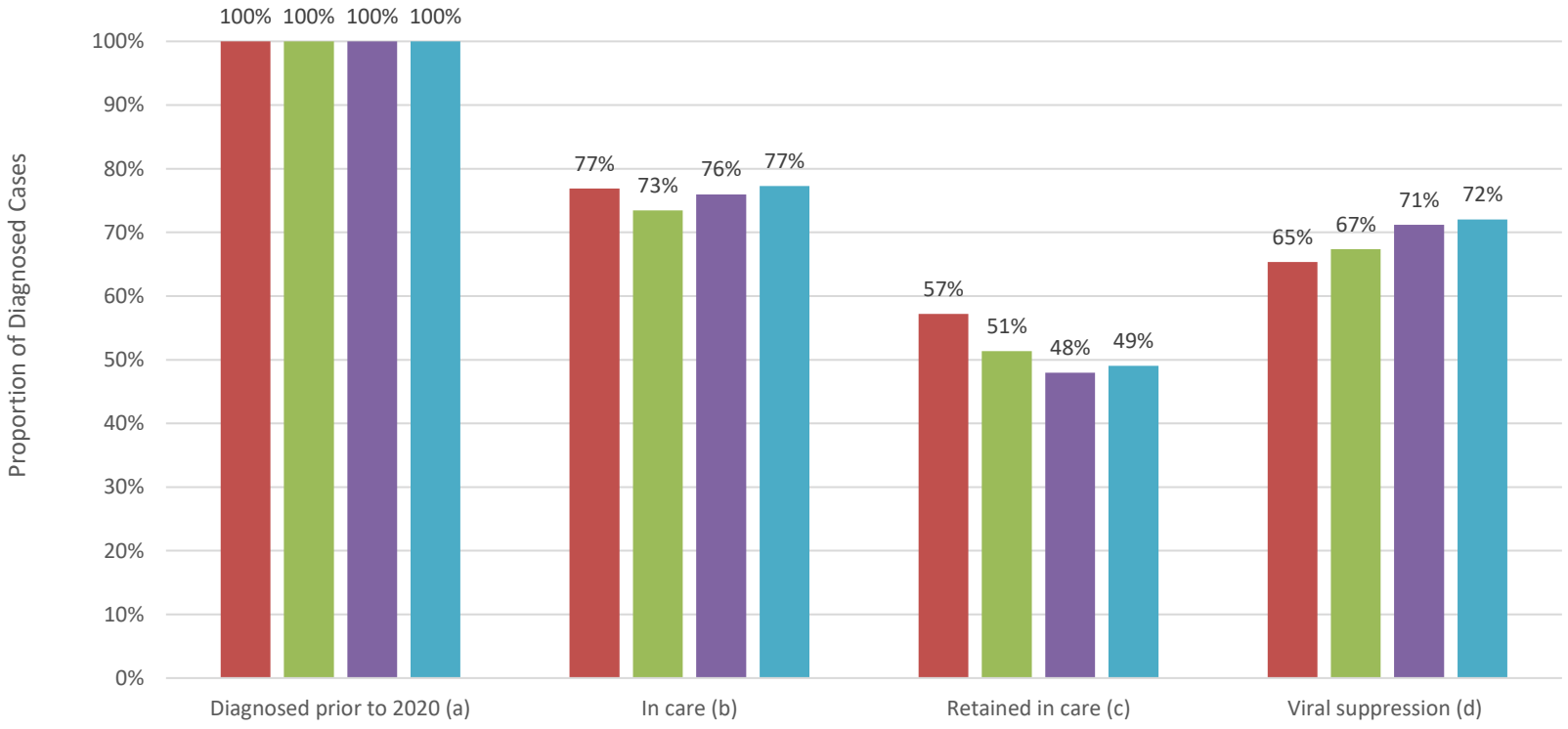
The chart on the following pages depicts the HIV care continuum for the San Francisco EMA for calendar year 2020. As noted on the table, the EMA has achieved significant success in linking and retaining persons in care and in achieving viral suppression across the region. A total of **76.3%** of all persons with a confirmed HIV diagnosis currently living in the EMA are engaged in care, defined as at least 1 CD4, viral load, or HIV genotype test during calendar year 2020, while **70.0%** had achieved viral load suppression at the time of the most recent viral load test, defined as less than 200 copies per ml. Additionally, **50.73%** of SF EMA PLWH were retained in care in 2020, based on a definition of at least 2 reportable HIV-related lab tests at least 3 months apart in a calendar year – a significant achievement given the numerous barriers to care retention and adherence that were presented by the COVID-19 pandemic. The percentage of persons retained in care also reflects a new standard in which individuals who have been durably virologically suppressed and on stable ARV regimens for an extended period of time attend **annual** medical visits as opposed to bi-annual visits. The significantly higher percentage of persons with durable viral suppression compared to the number of persons with 2 or more medical visits in a year may speak to the success of this overall approach, although more information is needed to verify this.

Despite the region's success in achieving a high level of care engagement and viral load suppression, significant **disparities** in HIV continuum outcomes continue to exist, particularly in regard to **ethnicity**. As noted in the comparison chart that follows the overall HIV continuum table, while **72%** of white PLWH achieved viral suppression in 2020, only **65%** of Black / African American PLWH and **67%** of Latinx PLWH were virally suppressed in the same year. These and other disparities are aggressively addressed both in our proposed FY 2022 - FY 2024 EIIHA Plan and in our proposed FY 2022 Part A care retention strategies, which include population-specific initiatives to better ensure long-term retention and medication adherence, including the significant expansion of support for **medical case management** to provide focused retention support to populations facing complex life challenges. Interestingly, Black / African Americans achieved by far the **highest levels** of HIV care retention in 2020, defined as at least 2 HIV-related lab test per year, with a retention rate of **57%,** while Latinx PLWH had a care retention level of **51%** and whites had a level of **49%**. This higher level of care retention reflects the success of our EMA on prioritizing care retention and medication adherence for our region's most disproportionately impacted populations.



(a) Includes persons diagnosed before 2020 who were alive and residing in EMA at end of 2020.
(b) >= 1 CD4, VL or genotype tests during 2020.
(c) >= 2 CD4, VL and/or genotype tests at least 3 months apart during 2020.
(d) Last VL during 2020<=200 copies/mL.

HIV Continuum of Care Among Prevalent Cases by Race, 2020



(a) Includes persons diagnosed before 2020 who were alive and residing in EMA at end of 2020.
(b) >= 1 CD4, VL or genotype tests during 2020.
(c) >= 2 CD4, VL and/or genotype tests at least 3 months apart during 2020.
(d) Last VL during 2020 <=200 copies/mL.

3. Unmet Need

Please see **Unmet Need Framework** in **Attachment 4**, as well as the narrative below.

a. Method Utilized:

For the FY 2022 Part A application, the San Francisco EMA utilized the **required** method for data reporting, and did not utilize the enhanced method. This choice does not reflect any data system or other limitations in our region, but rather the extreme shortage of staff time available within the San Francisco epidemiology unit due to assignments related to the COVID-19 pandemic.

b. Unmet Needs Estimates:

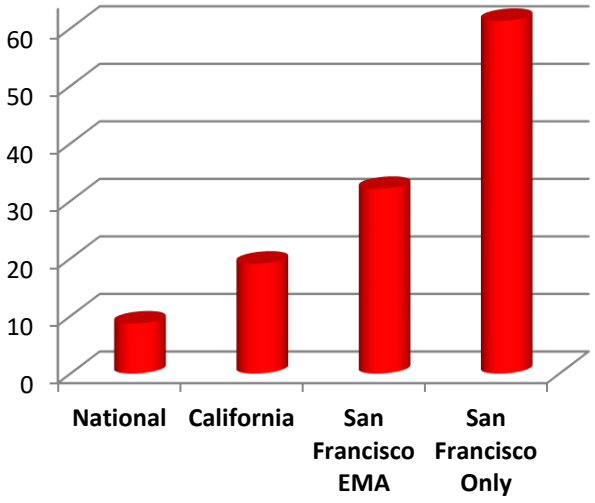
Based on the unmet need data prepared using the required data reporting method, the San Francisco EMA estimates that: a) **20.0%** of new 2020 HIV diagnoses occurred among persons who were diagnosed with an AIDS-defining condition within three months or less following their initial diagnosis; b) **23.8%** of all HIV-aware PLWH had not documented CD4 or viral load test in calendar year 2020; and c) **30.1%** of HIV-aware PLWH were not virally suppressed at the time of their most recent viral load test in calendar year 2020.

4. Co-Occurring Conditions

Please see **Co-Occurring Conditions Table** in **Attachment 5** as well as narrative below**.**

Sexually Transmitted Infections (STIs): The San Francisco EMA as a whole - and the city of San Francisco in particular - are in the midst of a growing and unprecedented epidemic of sexually transmitted infections. While this epidemic reflects a larger, ongoing epidemic affecting the entire State of California, it is having particularly acute consequences for our region, and speaks to our need to redouble our efforts to continue to reach and test persons at high risk for HIV. In terms of **syphilis**, for example, the SF Jurisdiction continues to confront a major epidemic that has been escalating for the past two decades, rising more than **550%** since 2000. In calendar year 2018 – the last date for which data is available due to delays related to the COVID-19 pandemic - a total of **635**

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



new primary and secondary syphilis cases were diagnosed in the three-county San Francisco region, representing a **177%** increase over the **229** cases reported in 2007.[20] The combined SF jurisdiction-wide syphilis rate of **32.1** per 100,000 in 2018 is significantly higher than the California statewide rate of **19.1** per 100,000. Within the City of San Francisco alone, a total of **544** new syphilis cases were reported in 2017 for an extremely high citywide incidence rate of **61.3** cases per 100,000, a rate **more than three times higher** than the statewide rate and **more than seven times higher** than the national syphilis rate of **8.7** cases per 100,000 in 2017 (see **Figure 8**). **San Francisco County has by far the largest syphilis infection rate of any of California's 59 counties, 41.8% higher** than the rate of the second highest county, San Joaquin County (**35.7** per 100,000) and nearly **three times** that of Los Angeles County (**23.0** per 100,000). The region is also experiencing a significant **gonorrhea** epidemic. A total of **6,823** new gonorrhea cases were identified in the San Francisco EMA in 2018, for a Jurisdiction-wide incidence of **359.4** cases per 100,000 – a rate **44.5% higher** than the 2018 California rate of **199.4** cases per 100,000 (see **Figure 9**).[21] The number of new gonorrhea cases in the City of San Francisco increased by **200%** between 2010 and 2018 alone, growing from **1,927** reported cases in 2010 to **5,894** cases in 2017. The City of San Francisco's 2018 gonorrhea incidence of **656.4** cases per 100,000 is **more than four times** the national rate of **145.8** cases per 100,000 and **more than three times higher** than the State of California as a whole (**199.4**). **This is again by far the highest rate of any county in California,** with the next highest county – Lake County –

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

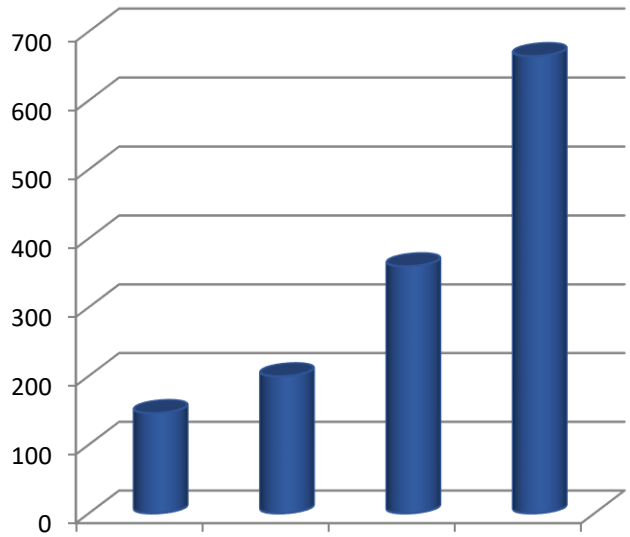
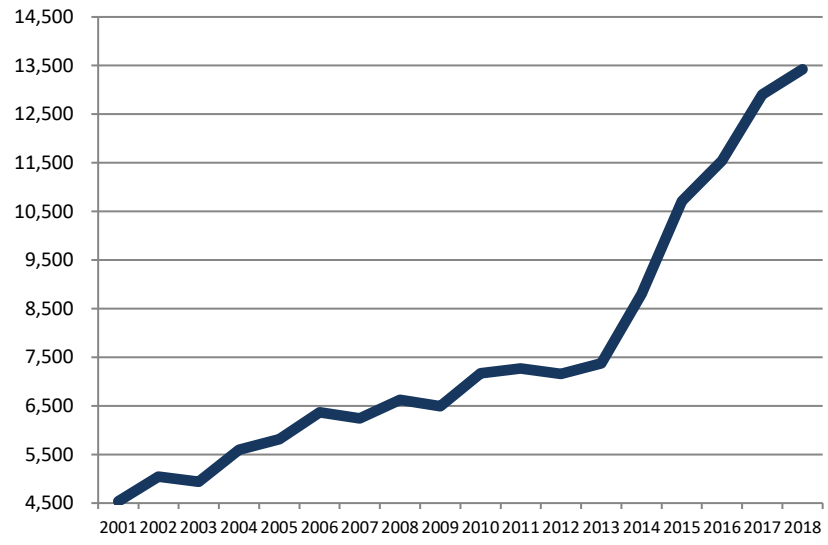


Figure 10. Annual Reported Chlamydia Cases - San Francisco EMA: 2001 - 2018



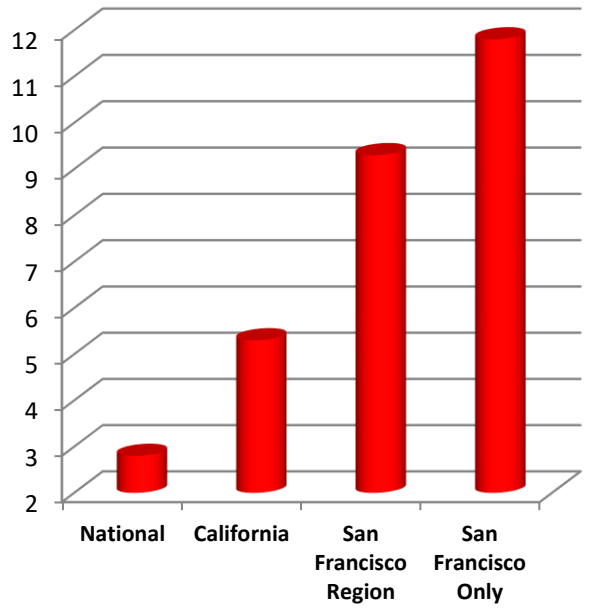
having a case rate of **262.4** per 100,000, **significantly less than half** the gonorrhea rate of San Francisco.

The region's **Chlamydia** epidemic also continues to grow, with rates rising significantly. A total of **13,423** new cases of Chlamydia were diagnosed in the three-county region Jurisdiction in 2018, representing a **131%** increase over the **5,816** cases diagnosed in 2005 (see **Figure 10**).[22] The 2018 Jurisdiction-wide Chlamydia incidence rate stood at **680.5** per 100,000, while the rate for the City of San Francisco was **1,070.9** cases per 100,000 - **again, by far the highest Chlamydia incidence rate of any county in California**. By comparison, the 2018 incidence for California was **538.0** cases per 100,000, while the national rate was **497.3.**

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

Tuberculosis (TB): Tuberculosis is an additional critical health factor linked to HIV, particularly among recent immigrants and the homeless. The magnitude of the local TB crisis is comparable to those of syphilis and gonorrhea, with a combined total of **179** new cases of TB diagnosed in the three-county region in 2019, representing an area-wide incidence of **9.3** cases per 100,000. In San Francisco, the incidence is even higher, at **11.8** cases per 100,000, although this is a decrease from the rate of **13.2** per 100,000 in 2018. San Francisco County's 2019 TB rate ranked **second** out of California's 58 counties, while San Mateo County ranked **fifth**. San Francisco's TB incidence rate is **more than double** the statewide rate of **5.3** cases per 100,000 and **nearly four times higher** than the national rate of **2.8** cases per 100,000 (see **Figure 11**).[27] Treatment for multi-drug resistant tuberculosis is particularly expensive, with one study indicating that the cost averaged $89,594 per

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



person for those who survived, and as much as $717,555 for patients who died.

Hepatitis C: The hepatitis C virus (HCV) is the nation's most common blood-borne infection, a major cause of liver cancer, and the leading cause of liver transplants in the US. In the United States as a whole, HCV prevalence is approximately **five times greater** than HIV prevalence, and approximately **25%** of HIV-positive individuals are co-infected with HCV infection.[23] Community-based antibody screening among high–risk populations in San Francisco has yielded a HCV antibody positivity rate of **5.4%,** while HCV antibody screening in San Francisco jails has yielded an antibody positivity rate of **10%.** Surveillance data also indicates tremendous disparities in HCV prevalence in San Francisco. While Black / African Americans represent **6.6%** of San Francisco's general population, they account for at least **one-third** of San Francisco's HCV cases and **23.5**% of the population of people who are co-infected with HIV and HCV. The San Francisco Department of Public Health also estimates that as many as **90%** of all chronic injection drug users over the age of 30 have HCV. Despite the tremendous disease burden of HCV, there has historically been a dearth of federal, state, and local funding for HCV surveillance, prevention, and care activities.

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

Additional Co-Factors: The high prevalence of **mental illness** and **mental health issues** in the San Francisco EMA complicates the task of delivering effective services and retaining persons with HIV in care. The San Francisco Department of Public Health Behavioral Health Section's most recent report noted that **12,000** seriously emotionally disturbed children and youth and **32,000** seriously mentally ill adults live in San Francisco, and that up to **37%** of San Francisco's homeless population suffers from some form of mental illness.[24] 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.[25] 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%.**[26] 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.[27]

Substance use also plays a central role in the dynamics of the HIV epidemic, creating challenges for providers while posing a critical barrier to care for HIV-infected individuals. The EMA is in the throes of a major substance abuse epidemic which is fueling the spread not only of HIV but of co-morbidities such as sexually transmitted infections, hepatitis C, mental illness, and homelessness **–** conditions that challenge the care system's ability to bring in and retain PLWH in care. According to the most recent report by the California Office of Statewide Health Planning and Development, an average of **8.5** hospitalizations per 10,000 occurred in San Francisco, well above the average statewide rate of **6.6** per 10,000.[28] 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.[29] Drugs and drug-related poisonings are also the **leading** cause of injury deaths among San Franciscans, **with an average of three San Franciscans dying each week of a drug-related overdose or poisoning**.[30] In terms of HIV, the most alarming current threat involves the local epidemic of **methamphetamine** (**speed or crystal**)**.** Health experts currently estimate that up to **40%** of gay men in San Francisco have tried methamphetamine,[31] and recreational crystal use has been linked to **30%** of San Francisco's new HIV infections in recent years.[32]

5. <u>Complexities of Providing Care</u>

a. <u>Reduction in Part A Formula Funding:</u>

i. <u>Impact:</u> For the seventh consecutive year, the San Francisco EMA experienced a reduction in Part A formula funding, with formula funds decreasing by $109,986 from FY 2020-21 to FY 2021-22, a reduction of **1.18%** in the formula award. Coupled with a reduction in Part A supplemental funding of **$282,834**, the SF EMA experienced a combined reduction of **$392,820** in Part A funding between the previous and current Ryan White fiscal years. The Planning Council utilized pre-established contingency plans which applied this reduction to proportional cuts in Part A support services.

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

b. Locally Available Health Care Coverage Options:

i. Coverage Options in the Jurisdiction and Their Impact on Health Care Service Access and Outcomes: The most important complementary funding stream to support HIV care for low-income populations is the **Medicaid** system, or **Medi-Cal**, as the system is known in California. Medi-Cal is an indispensable link in the chain of support for persons with low-incomes and HIV in the San Francisco EMA, and it has become an even more fundamental component with the advent of expanded ACA coverage. According to the data supplied for this application by the California Department of Health Services Research and Analytic Studies Division, between July 1, 2017 and June 30, 2018, Medi-Cal fee-for service reimbursements for persons with HIV in the San Francisco EMA totaled **$80,695,334,** an increase of **35%** over the **$60,909,907** in Medi-Call fee-for-services in the SF EMA between July 1, 2014 and June 30, 2015, attesting to our success in bringing larger and larger numbers of low-income persons with HIV into the Medicaid system. Fully **45.2%** of FY 2017-2018 HIV Medi-Cal expenditures (**$36,440,088**) supported the cost of HIV-related medications, which represents a significant reduction from the **75.8%** of Medi-Cal expenditures that went to prescription drug costs in 2014-2015. Meanwhile, **13.6%** of Medi-Cal HIV funds supported long-term care in 2017-2018 (**$10,973,237**), up from **10.1%** in 2014-2015; **5.4%** supported hospital inpatient care (**$4,326,653**) and **2.9%** (**$2,343,693**) supported the cost of HIV care at clinics**.** The San Francisco Planning Council examines changes in Medi-Cal data and takes this information into consideration in making its annual allocation of Part A primary medical care funding.

In addition to expanding Medicaid enrollment through LIHP, California was one of the very first states to develop a **state-based health insurance exchange** authorized by the ACA, which was conditionally approved to operate by the U.S. Department of Health and Human Services in 2011. The exchange, named **Covered California,** is essentially a **virtual marketplace** that allows citizens and legally recognized immigrants who do not have access to affordable employment-based coverage and are not eligible for Medicaid or other public coverage to purchase subsidized health insurance if they earn up to 400% of the Federal Poverty Level (FPL). Covered California health plans are also available to small employers through the Small Business Health Options Program (SHOP). In early 2013, the California Simulation of Insurance Markets (CalSIM) model predicted that at least 840,000 individuals with family incomes below 400% FPL would purchase insurance offered through Covered California and receive income-based premium tax credits to subsidize the out-of-pocket cost of coverage in 2014.[33] The vast majority of these individual are eligible for premium tax credits expected to range from 36% to 54% of enrollees in 2014.[34] In fact, during the historic first open-enrollment period from November 15, 2013 through April 15, 2014, more than **1.3 million** Californians chose health insurance through Covered California for coverage in 2014, while millions of additional Californians learned that they qualified for free or low-cost health coverage through Medicaid. Covered California today provides a critical bridge to affordable care for many persons with HIV in the San Francisco EMA whose incomes do not qualify them for expanded Medicaid coverage.

San Francisco residents have also had a longer-standing option of enrolling in the **San Francisco Health Plan,** a licensed community health plan created by the City and County of San Francisco that provides affordable health care coverage to over **100,000** low and moderate-income families. Created in **1994**, the San Francisco Health Plan's mission is to provide high

quality medical care to the largest number of low-income San Francisco residents possible, while supporting San Francisco's public and community-minded doctors, clinics, and hospitals. Health Plan members have access to a full spectrum of medical services including preventive care, specialty care, hospitalization, prescription drugs, and family planning services, and members choose from over **2,600** primary care providers and specialists, **9** hospitals and over **200** pharmacies – all in neighborhoods close to where they live and work.

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

The San Francisco EMA also relies on insurance co-payment options available through the **California Office of AIDS Health Insurance Premium Payment Program (OA-HIPP)**, which pays health insurance premiums for individuals with health insurance who are at risk of losing it and for individuals currently without health insurance who would like to purchase it. Since the implementation of the Affordable Care Act, the OA-HIPP has experienced a **63%** increase in the number of clients served by the program.[35] As of June 2014, the last date for which statistics are available, a total of **913** OA-HIPP clients were being subsidized for health insurance provided through Covered California while another **1,095** were being subsidized for insurance outside the ACA system. Because of this support, neither San Francisco nor San Mateo County is currently providing co-payments for individuals newly covered through ACA. Marin County funds a small number of annual co-payments on aa short-term basis to prevent individuals from losing their insurance.

c. Factors Limiting Access to Health Care / Service Gaps

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

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

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

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

"I love the San Francisco model. If it keeps doing what it is doing, I have a strong feeling that they will be successful at ending the epidemic as we know it. Not every last case - we'll never get there - but the overall epidemic. And then there's no excuse for everyone not doing it."
- Dr. Anthony S. Fauci,
Director, National Institute of Allergy and Infectious Diseases
***New York Times*, October 5, 2015[36]**

1. <u>Planned FY 2022 - FY 2024 EIIHA Activities</u>

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

The FY 2022 - FY 2024 EIIHA Plan will encompass **three** broad, high-impact prevention (HIP) activity areas that mirror those of preceding EIIHA plans and that build on the significant progress the SF EMA has made through its **Getting to Zero (GTZ)** initiative. The **first** area involves **identifying individuals who are unaware of their HIV status.** The EMA will continue to maintain: a) high-volume, community-based **targeted HIV testing** for MSM, persons who inject drugs/use drugs (PWID/UD), and transgender women, particularly persons experiencing homelessness within these populations, incorporating the latest testing technologies as appropriate, including high-quality rapid testing and acute RNA pooled screening and rapid 4th

generation combination antibody / antigen (Ab/Ag) tests at sites that do not have access to pooled RNA testing; b) integrated HIV/STI/Hep C testing wherever feasible and appropriate, incorporating chlamydia, gonorrhea, syphilis, hepatitis B and C, and tuberculosis testing; c) routine testing of partners of HIV-positive individuals; d) routine opt-out screening in clinical settings; e) routine perinatal screening; and f) accessible, high quality laboratory-based HIV testing and case reporting. At the same time, over the next three years, the SF EMA will cast a wider net to: a) address disparities in new infections among Black / African American and Latinx populations and b) find cases in low incidence populations such as women. These efforts will include: a) implementing culturally specific community engagement and mobilization within communities of color; b) further normalizing and de-stigmatizing HIV, Hep C and STI testing to reach beyond those who traditionally test by continuing to expand medically based HIV opt-out testing with 3rd party reimbursement; c) exploring opportunities to expand integrated approaches to sexual health services in novel settings such as HIV/STI screening and pre-exposure prophylaxis (PrEP) delivery at pharmacies; and d) focusing on mobile services and tele-health in response to the COVID-19 pandemic.

The **second** key activity area involves **ensuring that HIV-positive individuals are successfully linked to essential medical and social services based on individual need**. Specific activities to be undertaken through the Plan will continue to be tailored to meet the needs of its three identified target population groups, with a particular emphasis on continuing to implement the city-wide **Linkage Integration Navigation Comprehensive Services (LINCS) program** for both newly identified and re-linked individuals who have been out of care. Created in 2015, LINCS is a highly effective program designed to increase the number of HIV-infected individuals who are effectively linked to and anchored in care. The LINCS Team provides a comprehensive range of services based on individual client needs and circumstances, incorporating linkage to HIV medical care, social services, partner services, and retention services under a single umbrella. LINCS employs an integrated team of **15** full-time staff. **Eight** staff provide HIV and syphilis partner services and linkage to care to newly diagnosed patients, and **7** staff provide HIV care navigation to patients who are identified as out of care by healthcare providers or through HIV surveillance data. LINCS Team members are directly paired with newly identified HIV-positive individuals and remain paired in a supportive relationship for up to **three months** following initial HIV diagnosis. This ensures that: 1) linkage to care is made **within 30 days** for **everyone** testing positive in San Francisco; and 2) **all** newly-diagnosed individuals are offered comprehensive and immediate linkage and partner services.

The **third** key activity aims to **promote and facilitate ever-widening utilization of pre-exposure prophylaxis (PrEP) throughout the EMA**, and in particular, to address **disparities in PrEP uptake** in relation to under-utilizing populations such as Black / African Americans, Latinx populations, and transgender women. DPH is leveraging multiple funding sources to implement a multi-pronged approach that includes: 1) community, clinic, and pharmacy-based PrEP programs; 2) training of HIV test counselors to provide a gateway to PrEP; 3) social marketing; 4) mobile PrEP; and 4) public health detailing. San Francisco has vigorously embraced PrEP as an effective approach to reducing new infections among high-risk individuals in the EMA and has become known as the premier hub of PrEP use worldwide. In fact, San Francisco was originally chosen as one of two US sites for the global iPrEx study of once-daily Truvada use for gay men,

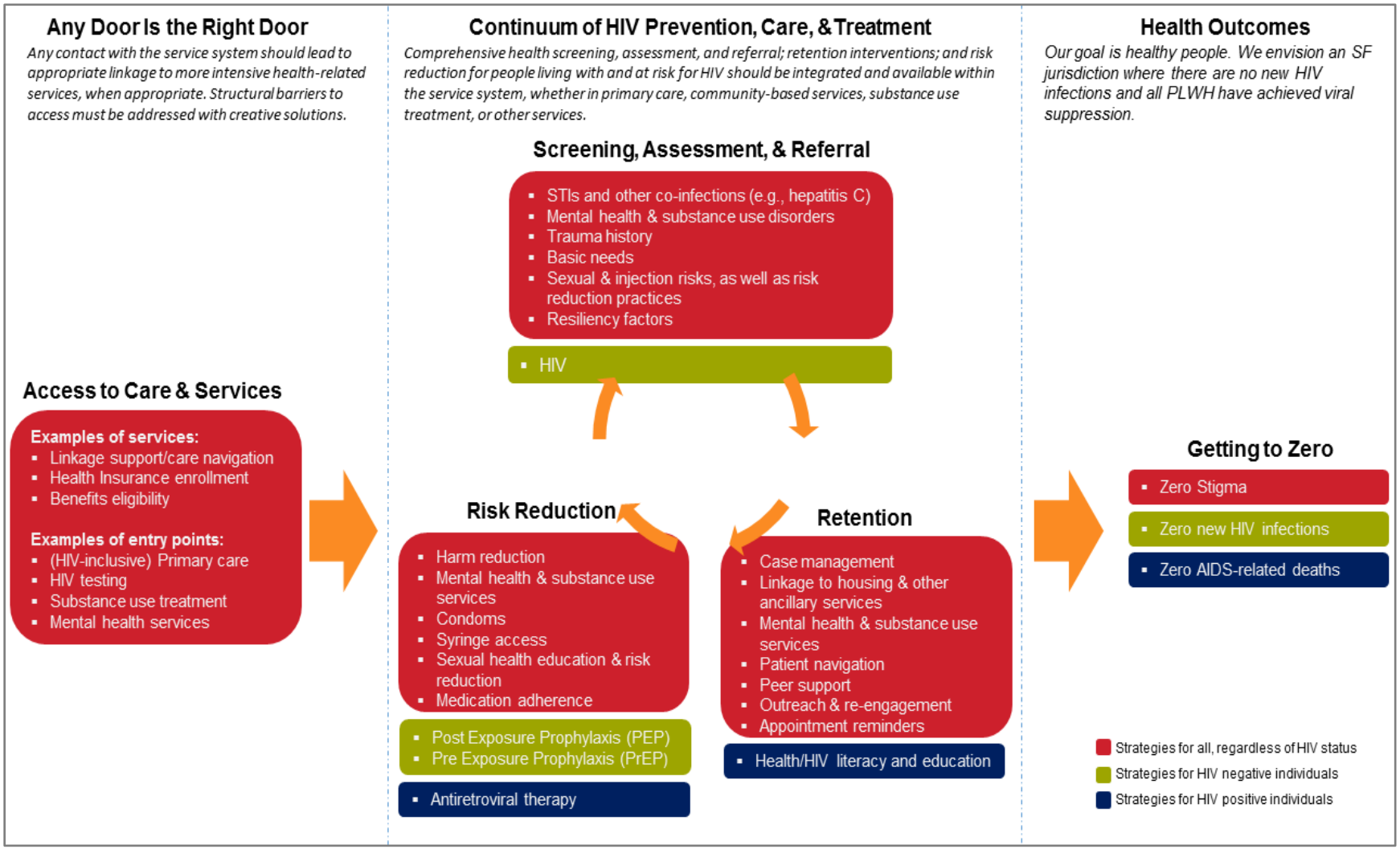
and established the nation's first PrEP demonstration project, which has since evolved into an ongoing program.[37] Key elements of San Francisco's PrEP strategy include the following:

- Reducing the interval from when a person wants to begin PrEP to receiving his or her first PrEP dose by increasing access to same-day PrEP;
- Facilitating connections between PrEP programs to ensure no one is on a waiting list;
- Utilizing California's PrEP Drug Assistance Program (PrEP DAP) when it becomes available;
- Increasing collaboration with the city's school district, its CDC Division of Adolescent and School Health (DASH)-funded program, and local colleges and universities to open additional access points for young MSM and trans female students;
- Incorporating post-exposure prophylaxis (PEP) into all PrEP discussions, so that clients who choose not to start PrEP know how to access PEP;
- Closely monitoring PrEP access for young MSM, trans women, and PWID/UD, who have particular challenges related to insurance and stability, making adjustments in our strategies as needed;
- Continuing to learn from communities about their unique barriers and support and work with community members to develop and disseminate culturally appropriate messaging to address misinformation and remove roadblocks to PrEP access;
- Strengthening panel management systems for PrEP programs at City Clinic (San Francisco's municipal STI clinic), the SFHN and CBOs to identify patients on PrEP who are lost to follow-up or have discontinued PrEP due to changes in insurance status, so there is no interruption in PrEP;
- Scaling up a pharmacist-delivered PrEP program at a community-based pharmacy in the Mission district serving Latinx clients;
- Ensuring that PrEP services and materials are available in Spanish and Portuguese;
- Integrating PrEP education for PLWH into Ryan White services and other services for PLWH, including PrEP referrals for their partners;
- Offering PrEP-related provider education and clinic capacity building opportunities;
- Providing PrEP starter pack and education during release from the SF County Jail;
- Expanding access through incentivized, mobile PrEP and through the PrEP program at SF City Clinic;
- Strengthening our collaboration with Alameda County to develop a regional PrEP approach; and
- Expanding harm reduction services at housing sites.

The SF EMA aims to achieve an HIV prevention and care continuum in which no one is at risk for HIV, and everyone who is living with HIV knows their status, is linked to and retained in care, and is virally suppressed (see **Figure 12**). The EIIHA Plan contributes to improving health outcomes in the following ways:

- Reducing at risk and HIV-infected populations by improving awareness and uptake of PrEP, with a particular focus on Black / African American and Latinx MSM, young MSM, and trans women;

Figure 12: San Francisco Jurisdiction Holistic Health Framework for HIV Prevention and Care



- Increasing awareness of HIV status through increasing access to routine HIV testing and community-based rapid testing to detect acute infections. SFDPH continues to promote frequent testing (every 3 to 6 months for the three high prevalence populations - MSM, PWID, and transwomen) and test counselors are trained to deliver this messaging during testing encounters. It is worth noting that the City of San Francisco has the highest rates of HIV status awareness in the nation with only 6% not aware of their infection, and with a sero-unaware rate of only 3% among MSM;
- Increasing opt-out HIV testing and PrEP uptake at Zuckerberg San Francisco General Hospital through a Clinical Champion and an Academic Detailer. The Clinical Champion is identifying HIV prevention champions across a range of inpatient clinical services (Internal Medicine, Family and Community Medicine, OB-Gyn, Surgery, Emergency Department, Urgent Care, Infectious Disease, Addiction Care team, etc.) and departments (Nursing, Pharmacy, Social Work, etc.) and convening an inpatient HIV prevention working group. The working group works to disseminate education, build provider capacity, collaborate on advocacy, and coordinate expansion of prevention interventions across services.
- Improving HIV care linkage and retention rates through continued implementation of the LINCS program as well as expanded case management services;
- Increasing viral suppression as a direct result of improvements along the rest of the continuum; and
- Continuing to conduct Data to Care (DTC) activities as a joint initiative between HIV surveillance and the LINCS program, with a special focus on Black / African American and Latinx MSM and trans women.

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

b. <u>Major Collaborations:</u>

HIV Health Services, which is housed in the ambulatory section of the San Francisco Health Division, works in close partnership with the three Branches in the Population Health Division - Community Health Equity & Promotion (CHEP)**,** Disease Prevention & Control (DPC), and Applied Research, Community Health Epidemiology & Surveillance (ARCHES) to plan services, design interventions, and share data and emerging findings. CHEP oversees community-based prevention and testing services; DPC oversees the LINCS program and operates City Clinic (the municipal STD clinic which offers HIV testing, PrEP, and HIV early care);

and ARCHES maintains the SF spectrum of engagement data as well as facilitating data to care and data to PrEP strategies. In addition, the DPH Primary Care Division is a close partner, providing routine HIV testing, care to people living with HIV, and PrEP access and navigation services.

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

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

To address syndemics and overlapping vulnerabilities, SF has also developed an **Ending the HIV/HCV/STI Epidemics (EtE) Plan (https://www.sfdph.org/dph/files/CHEP/SF-ETE-Plan.pdf)**. The plan was submitted to the CDC in December 2020 with a letter of concurrence from HCPC. IT was reviewed by the EHE federal partners and SF received positive feedback on the plan. The plan outlines strategies to address ongoing disparities and emphasizes community engagement by enabling the expansion of services to people living with HIV and/or vulnerable to HIV, HCV, and STIs. The approach includes status-neutral services with the goal of eliminating eligibility silos for prevention and care in order to turn the curve on HIV/HCV/STIs. The plan also centers racial equity with a focus on Black / African American and Latinx communities. Additional priority populations addressed by the plan include trans women; people experiencing homelessness; people who use drugs; and people who have experienced incarceration. The plan uses a harm reduction framework that seeks to eliminate stigma and discrimination and honor lived experiences and human dignity.

CHEP and HHS are coordinating SF's ETE planning and implementation and have established an internal SFDPH ETE Leadership Group that provides oversight and grant management for the CDC and HRSA EHE funding. We established a solid stakeholder group and Steering Committee as part of PS19-1906 that we continue to engage as we implement services. We have restructured the ETE Steering Community to be more community-led, and it will provide strategic direction on specific topics including racial equity, community engagement, workforce development, and status neutral services. We provide regular updates to and collaborate with the HIV Community Planning Council (HCPC), SF Getting to Zero (GTZ), the Black / African American Health Initiative (BAAHI), End Hep C SF (EHCSF), HIV/AIDS Provider

Network (HAPN), HIV Frontline Organizing Group (FOG), the Office of Transgender Initiatives, and the Drug User Health Initiative (DUHI). The ETE Leadership Group and Steering Committee will guide the ETE implementation for the next 5-10 years.

Although not required by HRSA, in San Francisco the HCPC coordinates **Part B** services in conjunction with Part A services to maximize the impact of these two funding streams. This service planning process is in turn coordinated with all relevant County units, including the Community Health Equity and Promotion and the Disease Prevention and Control Branches, in order to enhance regional efforts to identify and link to care persons with HIV who are unaware of their positive status. At the same time, representatives of agencies receiving funds through Ryan White Parts C, D, and F play an active role on the Planning Council to ensure integration and coordination of EIIHA activities with other Ryan White-funded services.

c. <u>Anticipated Outcomes of the Regional EIIHA Strategy:</u>

The FY 2022 - FY 2024 San Francisco EMA EIIHA Plan has **three** primary goals: **1)** to increase the percentage of individuals in Marin, San Francisco, and San Mateo counties who are aware of their HIV status; **2)** to increase the percent of HIV-positive individuals in our region who are effectively engaged in HIV care; and **3)** to reduce disparities in PrEP uptake, HIV infection, HIV testing, and successful and sustained linkage to care. SF EMA's EIIHA plan also includes approaches designed to reach the specific communities and individuals who are most vulnerable to HIV infection **before** they become infected. If GTZ is successful, the need for an early intervention plan should greatly diminish, because new infections will be virtually eliminated.

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

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

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

The FY 2022 - FY 2024 San Francisco EIIHA plan will reach many individuals who are disconnected from the system in order to bring them into HIV prevention, testing, linkage, and care services. Routine HIV testing, targeted community outreach, expanded case management

services, and PrEP services specific to underserved communities will help to reduce disparities among groups such as MSM of color, people who use drugs, Black / African American women, uninsured and economically impoverished populations, people experiencing homelessness, people with a history of incarceration, and young MSM – all populations that have experienced historical HIV access and treatment disparities along with high rates of late HIV testing. The San Francisco EMA will utilize its EIIHA plan and matrix to focus on increasing awareness of HIV status and promoting treatment utilization among underserved populations as a way to continue to address HIV-related health disparities.

2. <u>Legal Barriers and Solutions</u>

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

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

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

- California Senate Bill 233, signed into law by Governor Gavin Newsom on July 30, 2019, **prohibits the arrest of persons in the sex trade** who are reporting sexual assault, domestic violence, and other violent crimes, or who are in possession of condoms.
- Current California law requires that every patient who has blood drawn at a primary care clinic, and who has consented to the test, be offered an HIV test that is consistent with the United States Preventive Services Task Force recommendations for screening for HIV infection. A bill passed in September 2016 created a pilot project, administered by the State Department of Public Health, to assess and make recommendations regarding the effectiveness of the routine offering of an HIV test in the emergency department of a hospital.
- On October 6, 2017, Governor Brown signed into law landmark legislation to reform outdated laws that had unfairly criminalized and stigmatized people living with HIV. Senate Bill 239 updated California criminal law to approach transmission of HIV in the same way as transmission of other serious communicable diseases. It also brought California statutes up to date with the current understanding of HIV prevention, treatment, and transmission. The bill fulfilled a key goal of the National HIV/AIDS Strategy and is consistent with guidance from the U.S. Department of Justice and with California's "Getting to Zero" HIV transmission reduction strategy.
- At the current time, local health jurisdictions in California do not have access to data on prescribed PrEP medications for persons at risk for HIV. This makes it difficult to ascertain both the scope of PrEP treatment in our region, and the specific demographics of PrEP populations, which would in turn allow us to identify and address PrEP utilization disparities. The San Francisco EMA is supporting efforts to give access to PrEP prescription data for persons not currently infected with HIV, a shift that is made more likely with the advent of **PrEP Assistance Programs (PrEP-AP)** which help support the cost of PrEP medications for qualifying individuals.

C. Subpopulations of Focus

1. <u>Identification of Subpopulations of Focus:</u>

For the upcoming FY 2022 - FY 2024 Part A project period, the following **three** subpopulations of focus have been chosen to serve as the key target groups around which both Part A services and related EIIHA interventions will be focused over the next three fiscal years:

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

The San Francisco EMA's subpopulations have been selected on the basis of **three** key factors. **First**, from an epidemiological standpoint, these three subpopulations together encompass at least **90.9%** of all persons currently living with HIV in the San Francisco EMA. MSM alone – including MSM who inject drugs – make up **82.1%** of all persons living with HIV cases in the region as of December 31, 2020, while non-MSM PWID make up another **6.0%** of

all local PLWH (see HIV/AIDS Demographic Table in **Attachment 3**). Meanwhile, transgender females who have sex with males make up at least **2.8%** of all PLWH in the EMA, including **1.1%** who have a history of injection drug use. **Second**, the subpopulations represent the three groups most highly prioritized in the EMA's 2017-2021 Integrated HIV Prevention and Care Plan, a product of intense study and collaborative planning. And **third**, the selected subpopulations contain the highest rates of new HIV diagnoses as reported through HIV testing data, comprising **79.6%** of all newly diagnosed persons with HIV for the period January 1 - December 30, 2020.

2. <u>Use of Unmet Need Framework Data in Informing Subpopulation of Focus Selection:</u>

Data from the unmet need framework confirm the significant work the San Francisco EMA still has to do in addressing gaps and shortfalls in early HIV testing, adherence to medical care, and regional viral suppression. Fully **23%** of all non-MSM persons who inject drugs who were newly diagnosed with HIV in 2020, for example, were identified as late HIV testers (n=**13**), as compared to an overall rate of **20%** within the EMA. Similarly, **23%** of all newly identified MSM / IDU cases were late testers in 2020 (n=**13**). By comparison, only **9%** of newly diagnosed PWID and **4%** of newly diagnosed MSM / PWID were identified as late testers in 2016, only five years ago. Similarly, over **90%** of persons who did not have at least one CD4 or viral load test in 2020 or who did not achieve viral load suppression were members of the subpopulations of focus.

3. <u>EIIHA Activities to Address Needs of Subpopulations of Focus:</u>

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

Among many recent strategies introduced in our region, San Francisco has originated the highly influential and impactful **Rapid Antiretroviral Program Initiative for New Diagnosis (RAPID)** initiative**,** a program that began at Zuckerberg San Francisco General Hospital 3 years ago and has now expanded to HIV clinics citywide and has been adopted by other jurisdictions and metropolitan areas in the US. RAPID is a comprehensive initiative designed to help clients overcome the financial and social barriers to undergoing testing for HIV and being linked to care.[38] RAPID seeks to reduce the time between diagnosis, linkage to a primary care provider, antiretroviral initiation, and viral suppression. Through RAPID, five-day "treatment packs" are dispensed to new clients entering the clinic on the **same day** they have received an HIV diagnosis, while a full set of labs are drawn and the patient meets with a social worker to ensure coverage for the continuance of the ART medications. RAPID not only promotes patient health through early engagement in treatment, but plays a significant role in preventing new infections by reducing infectivity when patients are experiencing acute HIV syndrome, during which they are at greatest risk to pass the virus on to others. The RAPID program is able to

provide immediate medication linkage for clients linked at HIV testing sites throughout San Francisco, and has been extremely effective in helping the city meet its long-term testing and treatment goals.

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

- **METHODOLOGY**

A. Planning Responsibilities

1. <u>Letter of Assurance from Planning Council Chairs</u>:

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

2. <u>Resource Inventory:</u>

a) <u>Coordination of Services and Funding Streams:</u>

i. <u>Jurisdictional HIV Resources Inventory:</u> Please see table in **Attachment 7.**

<u>Narrative Resource Inventory Description:</u> The San Francisco HIV Health Services Planning Council and the SF Department of Public Health work together to ensure that Ryan White Part A funds are coordinated across all applicable funding streams in the region and that they address identified service gaps at all levels of client care and support. The Planning Council

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

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

- **WORK PLAN**

A. HIV Continuum Table and Narrative

1. HIV Care Continuum Table: Please see table in **Attachment 8.**

2. HIV Care Continuum Narrative:

a. Continuum of Care Changes from CY 2017 to CY 2019:

The HIV care continuum table has continued to reflect the San Francisco EMA's commitment to **steady, incremental improvements** across all stages of the HIV care continuum. The EMA continues to project annual increases of at least **1%** across all continuum categories based on the most recent year's baseline continuum data. The continuum of care framework embodies an approach to comprehensive care which has an increasingly important impact on integrated HIV prevention and care service planning in the San Francisco region. The continuum of care sets clear benchmarks to track our progress toward key HIV outcomes in the region, and allows us to compare our own regional outcomes to outcomes in other health jurisdictions. At the same time, analysis of continuum-related disparities shows us where we are falling short in terms of reaching and serving specific HIV-affected subpopulations and serves as a guide to allow us to more effectively allocate resources to eliminate disparities and achieve health equity. The Planning Council reviews the region's most recent continuum of care data during its annual prioritization and allocation process - along with a corresponding disparities analysis - to ensure that its funding strategies will continue to have the greatest impact on all aspects of the continuum, with the ultimate goal of achieving viral suppression among the greatest possible number of PLWH in our region.

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

B. Funding for Core and Support Services

1. Service Category Plan:

a) Service Category Plan Table: Please see table in **Attachment 9.**

b) MAI and Overall Service Category Plan Narrative:

i. How General and MAI Services Address the Needs of Subpopulations of Focus: The FY 2022 Part A Plan requests a total of **$15,590,728** Formula and Supplemental funding to allow the SF EMA region to continue to meet escalating client needs in an effective and strategic manner. This represents a **3.3%** reduction from the **$16,126,350** requested by the EMA for the 2020 Ryan White fiscal year. Direct service allocations make up **88.5%** of this request, for a total of **$13,791,511**. Another **$381,878** supports EMA-wide quality management activities, while **$1,417,339** supports administrative costs for the recipient agency, including San Francisco Planning Council expenses. Reflecting HIV caseload proportions in the EMA's three counties, approximately **9.2%** of the FY 2022 direct service request is expected to support HIV client services in **San Mateo County**, while another **3.5%** is expected to support direct HIV services in **Marin County**. The remaining service allocation supports persons living with HIV in the City and County of San Francisco.

The large majority of proposed FY 2022 service expenditures – **62.0%** of total requested service dollars (**$8,543,387**) - supports the provision of direct care services in HRSA-identified **core service categories** (see **Figure 13** on following page) . **As noted above, over 90% of these services will directly seek to meet the needs and address HIV continuum of care outcome disparities for members of our project's three identified subpopulations.** Of this year's total direct service request, a total of **$2,806,099** is requested for **outpatient / ambulatory health services** (including **$499,443** in Part A MAI funds), an amount representing **20.4%** of the total core services request. This category includes support for ambulatory care services delivered in community and institutional settings as well as the **seven regional Centers of Excellence** that build upon and enhance San Francisco's highly successful integrated services approach to care. Additional HRSA core categories for which significant funding is requested in the FY 2022 Plan

Figure 13. San Francisco EMA Summary of FY 2022 Ryan White Part A Grant Request		
Allocations Categories	**Amount**	**Percent**
1. Core Medical Services Subtotal	**$ 8,543,387**	**61.95 %**
a. Outpatient /Ambulatory Health Services: ▪ MAI Request: ▪ Non-MAI Request:	 $ 414,442 $ 597,674	 3.01 % 4.33 %
b. AIDS Drug Assistance Program (ADAP) Treatments		
c. Oral Health Care	$ 830,193	6.02 %
d. Early Intervention Services	$ 115,224	0.84 %
e. Health Insurance Premium & Cost Sharing Assistance	$ 54,950	0.40 %
f. Home Health Care	$ 275,378	2.00 %
g. Home and Community-based Health Services		
h. Hospice Services	$ 823,592	5.97 %
i. Mental Health Services:	$ 1,445,906	10.48%
j. Medical Nutrition Therapy		
k. Medical Case Management (including Treatment Adherence): ▪ MAI Request: ▪ Non-MAI Request:	 $ 207,890 $ 3,475,534	 1.51 % 25.20 %
l. Substance Abuse Services – Outpatient ▪ MAI Request: ▪ Non-MAI Request:	 $ 87,969 $ 214,725	 0.64% 1.56%
m. AIDS Drug Assistance Program Treatments		
2. Support Services Subtotal	**$ 5,248,124**	**38.05 %**
a. Non-Medical Case Management Services	$ 2,019,435	14.63 %
b. Child Care Services		
c. Emergency Financial Assistance	$ 1,157,816	8.40 %
d. Food Bank/Home-Delivered Meals	$ 257,584	1.87 %
e. Health Education/Risk Reduction		
f. Housing Services	$ 730,984	5.30 %
g. Linguistics Services		
h. Medical Transportation	$ 9,817	0.07%
i. Outreach Services	$ 277,964	2.02 %
j. Psychosocial Support Services	$ 498,966	3.62%
q. Other Professional Services (Legal)	$ 295,558	2.14 %
3. Total Service Dollars	**$ 13,791,511**	**100.0 %**
4. Clinical Quality Management Activities	**$ 381,878**	
5. Grantee Administration	**$ 1,417,339**	
6. Total Allocations	**$ 15,590,728**	

include: a) **Medical Case Management** which links and coordinates assistance from multiple agencies and caregivers in order to ensure access and promote retention in care and adherence to medical treatment (**$2,192,045,** including **$289,780** in requested MAI funds); b) **Mental Health Services,** including Crisis and Outpatient Mental Health Services (**$1,445,906**); c) **Oral Health Care** to address dental manifestations of HIV and preserve client health (**$820,193**); d) **Hospice Services** supporting room, board, nursing care, counseling, physician services, and palliative care for clients in terminal stages of illness (**$823,592**); and e) **Home Health Care** to meet direct medical treatment needs outside of inpatient and clinical settings (**$275,378**).

ii. <u>How MAI Services Address Key Needs Within the Subpopulations of Focus:</u> The San Francisco EMA will utilize Part A MAI funds specifically to support services for low-income HIV-infected Latinx populations. While some service dollars incidentally support other populations of color with HIV, local MAI funds are almost exclusively focused on ensuring culturally and linguistically appropriate services to this large and rapidly growing PLWH population. Latinxs are the fastest growing group of HIV-infected persons in the EMA by ethnicity, making up **39.8%** of all new HIV diagnoses in CY 2020 alone, despite comprising **18.9%** of the EMA's population. Between 2011 and 2019, the number of Latinx PLWH in the SF EMA grew by **60.7%**, from **15.5%** to **24.9%** of total PLWH. According to the Pew Research Center, **29%** of Hispanics in California lack any form of health insurance and **25%** of Hispanics 17 and under live below the Federal Poverty Line.[39] Latinx populations also comprised by far the largest proportion of late HIV testers identified in 2020, at **39.2%** (**60** of **153** total late testers), as compared to whites, who made up **28.8%** of late testers, and Black / African Americans, who made up **19.0%** of 2020 late testers. Additionally, at the end of 2020, Latinx PLWH made up **26.7%** of all MSM PLWH, **24.9%** of PWID PLWH, and **20%** of all transgender women living with HIV in San Francisco.

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

Minority AIDS Initiative funds have had a major impact on the San Francisco EMA, allowing us to identify, reach, and bring into care a significant number of highly disadvantaged persons of color, in turn reducing service disparities and improving health outcomes across the region. FY 2020-2021 Part A MAI funding enabled the EMA to provide critical medical, case management, and primary services to **over 320** impoverished clients of color, many of whom are transgender persons. MAI funding has enabled the San Francisco system of care to be well-positioned to address the growing care needs of disproportionately impacted Latinx populations, including Latinx MSM.

c) Unmet Need

i. Interventions to Improve Outcomes for Individuals with Unmet Need in Relation to Unmet Need Categories: While Section C.3 above describes a number of core activities that have a direct impact on the health and care engagement of Latinx PLWH, SFDPH is continually implementing new initiatives designed to improve HIV care continuum outcomes as they relate to communities of color in the SF EMA. For example, San Francisco has recently implemented an innovative series of **mini-grants for community-based organizations** that have deep connections to the populations of focus. These mini-grants fund innovative approaches to harnessing and amplifying community voices in influencing HIV prevention and care efforts. The second round of grants began in August 2020, and fund the following **six** organizations for these Community Advisory Processes (CAPs):

- **SF Community Health Center:** "Leading from Within for Trans Women," an employment readiness program for trans women that provides proper training and clear benchmarks for growth.
- **SF Community Health Center:** "Leading from Within for People Experiencing Homelessness and Housing Instability," a workforce development program for Community Experts (CEs) to gain more experience and knowledge that can assist them in building community with other PEHHI (past or present) and growing personal and professional skills.
- **AIDS Project of The East Bay:** "The Messenger Matters for Black / African-American Communities," a community advisory board to identify next generation Black LGBTQ community leaders and cultivate their professional development and public health knowledge and skills through a variety of interactive workshops and innovative activities.
- **Code Tenderloin: "**Empowering Black Youth to Redefine Sexual Health in San Francisco," a 7 month paid internship promoting sexual health education for Black youth ages 13-24
- **MPact Fijate Bien:** Community-based participatory action research for Latinx communities that includes training for community members to participate in a "secret client" pilot.
- **GM Consulting:** Building capacity of a promotoras/promotores model and providing workforce development opportunities for Latinx communities.
- **WISE Health:** "Equity Design Workshops" to engage health professional students, community health workers, case managers and professional individuals working within San Francisco's communities of color.

San Francisco also continues to implement **Project OPT-IN** (Outreach, Prevention & Treatment Initiative), specifically designed to reduce HIV-related disparities and health inequities across the spectrum of prevention, care, and treatment for **people experiencing homelessness who are living with and at risk for HIV.** The vision of Project OPT-IN is to create a network of homeless services that meets the needs of people living with or at risk for HIV, providing them with all the resources and support needed to stay HIV-negative or virally suppressed. Among other innovations, Project OPT-IN conducts homeless health outreach both at the individual level and through inter-agency partnerships, identifies new or out of care persons experiencing homelessness who are living with or at risk for HIV, and collaborates with medical and social service providers to link and anchor these individuals in care. Project OPT-IN

will improve HIV-related outcomes across the care continuum by providing services to address critical gaps in HIV prevention and care services for the target populations, while simultaneously working to transform systems and practices, thus reducing the long-term need for such services. San Francisco is also working toward becoming one of the first cities in the US to implement an **overdose prevention consumption site** under the leadership of the city's mayor, London Breed. The site will provide a space for persons to inject drugs safely without fear of arrest, while accessing HIV testing and other supportive and treatment services. As noted above, San Francisco has also funded the development of the Micro-Elimination Plan to treat and eliminate Hep C among residents with HIV.

ii. <u>Relationship to Existing Local Plans:</u> The 2017-2021 San Francisco EMA Integrated HIV Prevention and Care Plan embraces a health equity approach to HIV prevention, care, and treatment as its focus going forward. The Plan includes numerous potential strategies to be considered by the merged Planning Council in addressing disparities, including:

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

- **RESOLUTION OF CHALLENGES**

Please see table beginning on the following page.

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

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

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

- **EVALUATION AND TECHNICAL SUPPORT CAPACITY**

A. Clinical Quality Management (CQM)

1. <u>Overview of CQM Program and Recent Changes:</u>

The San Francisco EMA maintains a well-established quality management infrastructure that enables consistent analysis and problem solving of issues related to client care and to lack of equity in regard to HIV care outcomes. The **Director of HIV Health Services,** Bill Blum, oversees the creation, implementation, and evaluation of continuous quality improvement (CQI) activities that are in turn supervised and managed by the **Center for Quality Improvement and Innovation.** The SF DPH **HIV Health Services Continuous Quality Improvement Committee**, comprised of members with diverse perspectives on quality of care, is responsible for selecting and implementing a targeted and specific CQI effort for Ryan White Part A funded providers annually and updating the local Quality Management Plan. The Committee also prioritizes and implements new QI projects; provides continuous QI and topical training; responds to providers' needs by utilizing the **Center for Quality Improvement and Innovation**'s (CQII) Quality Indicator measures and tools; and updates performance indicators to satisfy quality measures. The chart below briefly outlines responsibilities of staff and committees involved in the EMA's quality improvement efforts (see **Figure 14**):

Figure 14.
Chart of Responsibilities for SF EMA Clinical Quality Management Program

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

Figure 14. Chart of Responsibilities for SF EMA Clinical Quality Management Program	
Individual / Entity	**Role / Responsibilities**
▪ **San Mateo and Marin Co. QI Representatives**	▪ Oversees all Quality Management activities in their counties and respective providers.

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

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

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

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

Since the end of Ryan White 2018-19 Fiscal Year, HHS has been implementing a CQI initiative specifically focused on improving viral load suppression among Black / African American clients and eliminating this health disparity. The HHS CQI Committee has convened monthly meetings of a broader CQI Committee made up of HHS-funded Primary Care, CoE, and Medical Case Management providers to focus on both their individual efforts to address health equity related to African-American viral load suppression (VLS), and to discuss system-wide efforts to work jointly toward implementation of such measures. In total, **11** different programs send key staff to the **"Improving African-American Viral Load Suppression Equity" Committee** which meets every other month. **As of September 2021,** clinical data collected by the committee indicated that **six** programs involved in this CQI activity have eliminated this disparity and **only two** programs have a need to increase VLS among only **one** of their African-American clients in order to achieve equity within their program. In total, the committee has established a targeted goal of **12** African-American clients across **3** programs achieving VLS in order to reach and maintain health equity for this CQI measure.

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

For agency-specific issues, the EMA has established a **written protocol** for accessing Technical Assistance through the Quality Management Program. As agency-specific issues arise, they are discussed with the Director and Assistant Director of HIV Health Services, the DPH Business Office of the Contract Compliance Manager, and the Quality Management Consultant. Typically, a written technical assistance plan is developed – such as a chart review or staff training – and implemented with one of the Quality Management TA consultants and the agency. Progress is updated with the Business Office of the Contract Compliance Manager, Contract Development Manager, and the Technical Assistance Manager. If required, a report, including any further recommendations, is submitted to the HIV Health Services Assistant Director and Director, as well as the agency, at the completion of the technical assistance period.

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

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

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

Based in part on quality management data received, the San Francisco Planning Council has reaffirmed the continuing focus of the EMA's Centers of Excellence on **persons with severe need** and **special populations from communities that typically experience health disparities**. Recent refinements made by the Planning Council based on the use of data include: a) expanding the EMA's definition of special populations to include PLWH age 60 and older; b) integrating existing Early Intervention Programs into the CoE model; and c) for the purposes of

the CoE, specifying the inclusion of individuals living in neighborhoods in which health disparities and HIV are co-prevalent including the Tenderloin, the Mission, South of Market, and the Southeast Corridor of San Francisco.

Recent trainings have been conducted on the following topics: **a) Trauma-Informed Care Within a Motivational Interviewing Frame:** This training identifies the principles of trauma-informed care and compares them to the principles of Motivational Interviewing and demonstrates how to use complex reflections to deepen and shape trauma-informed conversations. **b) A Trauma-Informed Approach: Examining Trauma, Power and Oppression:** this training reviews foundational language, definitions, and concepts related to a trauma-informed approach, power, and oppression; explores a trauma-informed approach through a power and oppression lens; teaches the basic tools to better support clients through a trauma-informed and oppression-sensitive lens; and identifies the impacts of trauma and oppression on client & staff interactions. **c) Tools for Conflict Resolution, De-escalation, and Support – Working with Clients Who Have Experienced Poverty, Violence and Other Traumas:** This training gives an overview of the basics in communication skills necessary to avert and manage crisis situations, assessing the consequences of adrenalin on behavior and looking at the interaction of trauma and oppression on clients' lives and behaviors**. d) Emotional Exhaustion with HIV, Wellness and Stress Management:** This training identifies the causes, symptoms, and consequences of HIV Burnout while presenting tools and options for its prevention. **e) Unearthing Implicit Bias, Working Effectively with Diverse Populations:** This training offers practical skills to identify implicit bias in providers' interactions with clients and colleagues, and offers steps to support and repair relationships. **f) Effectively Supporting Safe Inclusive Spaces for LGBTQ Clients and Colleagues:** This workshop presents participants with the basic concepts, vocabulary, and skills necessary to provide the best support for intersex, transgender, and other sex/gender non-conforming clients and colleagues. **g) Racism and White Privilege: Navigating Difficult Personal Conversations on Racial Inequity:** This workshop deepens providers' understanding of the impacts of racism and reviews how cultural competency and racial identity education can support positive change. **h) Understanding and Interrupting the Cycle of Oppression:** This training introduces providers to the cycle of oppression and presents ways to dismantle the cycle by examining and understanding stereotypes, prejudice, discrimination, and social power. **i) HIV Nursing Network Conference:** HIV Health Services and the AIDS Education and Training Center provide this training annually for nursing staff in the EMA. Topics covered include HIV 101; Updates on HIV Prevention; Mental Health, Homelessness & HIV; Pharmacology Update; Intersection of STDs and PrEP; Managing Chronic Pain; Best Practices in Linkage and Retention; and a panel discussion with consumers across the continuum of care.

ORGANIZATIONAL INFORMATION

A. Grant Administration

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

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

The grantee agency for Ryan White Part A funds in the San Francisco EMA is the **City and County of San Francisco Department of Public Health (SFDPH).** Ultimate authority for the administration and expenditure of Part A funds lies with the city's **Mayor, London Breed**, and with the city's **11-member Board of Supervisors**, which acts as both county governing board and city council for San Francisco. This authority is shared with **Grant Colfax, MD for SFDPH** who now serves as **Director of Public Health** for the City and County of San Francisco (see Organizational Chart in **Attachment 10**). Dr. Colfax previously served as Director of National AIDS Policy under President Obama. The administrative unit overseeing the Part A grant is **HIV Health Services (HHS)**, an organizational unit of the San Francisco Department of Public Health, Primary Care division, overseen by **Roland Pickens,** who serves as **Director of the San Francisco Health Network** for the City and County of San Francisco**.** The **Director of HIV Health Services** is **Bill Blum, LCSW,** who has served in this capacity for **11½ years** and who also serves as **Director of Programs for Primary Care in DPH**. A staff of **9 SFDPH** employees (**8.8 FTE**) – RWPA funding 2.73 of these FTE at HHS – is responsible for directing, coordinating, and monitoring the distribution and expenditure of Part A funds throughout the EMA, working a combined total of **5.47 FTE** with Part A funding. Additionally, a combined total of **1.76 FTE** of staff time is dedicated to Business and Finance Services; **0.33 FTE** to Surveillance/Epidemiology; and **0.65 FTE** to the Contracts Administration section (see attached Budget Justification for description of individual staff roles and percentages).

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

Planning Council Support, Mark Molnar, is a former long-term member of the SF HIV Planning Council and previously served as Co-Chair. Since the onset of the COVID pandemic the HIV Community Planning Council has adapted to hold all general body and committee meetings virtually via Zoom.

The two additional counties that make up the San Francisco EMA have responsibility for administering and distributing Part A funds through their counties' respective health departments. In San Mateo County, Part A and Part B funds are coordinated through the **San Mateo County Health Department's Director, Louise Rogers**. Responsibility for Part A fund administration lies with **Matt Geltmaker,** who serves as **Director of the San Mateo County STD/HIV Program** and is responsible for oversight of all Ryan White Part A, Part B, MAI, CDC, HIV prevention, and HOPWA funds as well as subcontractor oversight. In Marin County, Parts A and B funds are administered through **County of Marin Health and Human Services**, whose Director is **Benita McLarin.** She shares responsibility for Part A funds with **Ken Shapiro, Chief Operating Officer.** The **Marin County HIV/AIDS Program** has direct responsibility for Part A fund management and coordination. Direct oversight of Marin County Part A funds is provided by **Cicily Emerson, Community Health and Prevention Services Manager** for the County. An EMA-wide Organizational Chart outlining the above relationships is included in **Attachment 10** of this application.

b) Administration by a Contractor or Fiscal Agent:

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

2. Grant Recipient Accountability:

a) Monitoring:

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

For the **2021-2022** Fiscal Year (**3/1/21 - 2/28/22**), the San Francisco Department of Public Health is utilizing Ryan White Part A funding to support a total of **37** separate programs. These 37 programs are being operated by **20** different community-based organizations

(subrecipients), including local non-profits; the University of California San Francisco; and four programs administered by the local county health department. Typically, SFDPH Business Office Contract Compliance staff would conduct on-site monitoring visits to **all** of these programs each year and would conduct programmatic and fiscal monitoring visits to all programs in FY **2021** as well. However, due to the COVID-19 pandemic and as allowed by HRSA, no in-person site visits have been conducted **either last year or this year**. However, **remote desk audits** to review performance data, evaluate program performance objectives, and assess level of contract deliverables are still being conducted. **Monitoring Reports** have been written to evaluate those performance indicators in these and other areas which can be verified remotely. San Francisco's **Citywide Nonprofit Monitoring and Capacity-Building Program,** which conducts in-depth fiscal and compliance monitoring of all nonprofit contractors funded by two or more City departments, were also put on hold this fiscal year due to the pandemic.

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

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

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

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

b) Third Party Reimbursement:

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

ii. Documenting Client Screening for Eligibility and to Ensure that Ryan White is the Payer of Last Resort: Service providers are monitored to ensure compliance with Ryan White Program policy and guidelines pertinent to third-party reimbursement. Contracted service providers must provide a description of their screening practices for determining client eligibility for receipt of services, as well as a roster of all third-party payer sources they utilize. Local health department policies in all three EMA counties mandate that if a client is found eligible for coverage from a payer source other than Ryan White – such as Medicaid, Medicare,

or private insurance – then that source **must** be billed before seeking reimbursement from Ryan White. **In these cases, payment received is considered as payment in full, and balance-billing to Ryan White is not permitted.** Technical assistance is provided where needed to ensure that agencies modify and improve their eligibility standards or attain greater competency in maximizing third-party billing procedures.

iii. Tracking Program Income and Rebates: HIV Health Services and the SFDPH Office of Contract Development and Technical Assistance require all agencies funded through Ryan White Programs to provide a complete budget summary of all program funding sources and incomes as well as program expenditures. All programs must demonstrate that their total program funding equals total program expenditures for each fiscal year in the budget.

c) Fiscal Oversight:

i. Process Used by Program and Fiscal Staff to Coordinate Activities and Ensure Adequate Reporting, Tracking, and Reconciliation of Program Expenditures: The staff of the City and County of San Francisco Controller's Office monitors federal funds awarded to nonprofit organizations. For nonprofit organizations receiving $750,000 or more in federal funds, the Controller's Office reviews audited financial statements and single audit reports for compliance with the Single Audit Act and OMB Circular A-133. In **Fiscal Year (FY) 2021**, the Controller will review single audit reports for a total of **31** SFDPH HIV Health Services-funded organizations including **all 16** Part A-funded community-based organizations. The Controller found that all of these organizations had appropriate and timely processes and practices in place in 2020.

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

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

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

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

bank account by SF's Auto Clearinghouse Payment Processing for those contractors who establish this mechanism with the City. Payments are processed once weekly.

B. Maintenance of Effort

Please see Maintenance of Effort report in **Attachment 12.**

ENDNOTES

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