File No.111117 Committee Item No. _____
Board Item No. 20

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Board of Supervisors Meeting **Date** October 25, 2011

Cmte	Board	
☐	☐	**Motion**
☐	☒	**Resolution**
☐	☐	**Ordinance**
☐	☐	**Legislative Digest**
☐	☐	**Budget Analyst Report**
☐	☐	**Legislative Analyst Report**
☐	☐	**Youth Commission Report**
☐	☐	**Introduction Form (for hearings)**
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☐	☐	**MOU**
☐	☐	**Grant Information Form**
☐	☐	**Grant Budget**
☐	☐	**Ethics Form 126**
☐	☐	**Subcontract Budget**
☐	☐	**Contract/Agreement**
☐	☐	**Award Letter**
☐	☒	***Application**
☐	☐	**Correspondence**

OTHER **(Use back side if additional space is needed)**

☐ ☐ _____
☐ ☐ _____
☐ ☐ _____
☐ ☐ _____

Completed by: Andrea Ausberry **Date** October 19, 2011
Completed by: _____ **Date** _____

An asterisked item represents the cover sheet to a document that exceeds 25 pages.
The complete document is in the file.

[Approval of the Ryan White HIV Emergency Relief Grant Program Application]

Resolution authorizing the San Francisco Department of Public Health to submit an application to continue to receive funding for the "HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A)" Grant from the Health Resources Services Administration, requesting $36,118,233 in HIV emergency relief program funding for the San Francisco Eligible Metropolitan Area from March 1, 2012, through February 28, 2013.

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

WHEREAS, DPH is currently a recipient of the "HIV Emergency Relief Grant Program" grant in the amount of approximately $36,118,233 from the HRSA for fiscal year 2011; and,

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

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

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

WHEREAS, HRSA released the application announcement on August 22, 2011 with a due date of November 1, 2011 allowing just 54 days for the entire process; and,

WHEREAS, in the interest of timeliness, DPH is making this request for approval by submitting its most recent draft of the grant application, also including supporting documents

as required, all of which are on file with the Clerk of the Board of Supervisors in File No. 111117, which is hereby declared to be part of the Resolution as if set forth fully herein; and, now, therefore, be it

RESOLVED, That the Board of Supervisors hereby approves DPH's application submission to HRSA for the "HIV Emergency Relief Grant Program (Ryan White Programs, Part A)" grant for the funding period of March 1, 2012 through February 28, 2013, to be submitted no later than November 1, 2011.

RECOMMENDED:

Barbara A. Garcia, MPA
Director of Health

OFFICE OF THE MAYOR
SAN FRANCISCO

EDWIN M. LEE
MAYOR

TO: Angela Calvillo, Clerk of the Board of Supervisors

FROM: for Mayor Edwin M. Lee

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

DATE: October 18, 2011

Attached for introduction to the Board of Supervisors is the resolution authorizing the San Francisco Department of Public Health (DPH) to submit an application to continue to receive funding for the "HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A)" grant from the Health Resources Services Administration (HRSA), requesting $36,118,233 in HIV emergency relief program funding for the San Francisco Eligible Metropolitan Area (EMA); from March 1, 2012 through February 28, 2013.

Please note this item is cosponsored by Supervisor Wiener

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

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

Cc Supervisor Scott Wiener

1 DR. CARLTON B. GOODLETT PLACE, ROOM 200
SAN FRANCISCO, CALIFORNIA 94102-4681
TELEPHONE: (415) 554-6141

111117

Edwin Lee
Mayor

Barbara A. Garcia, MPA
Director of Health

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

Funding Criteria

The San Francisco Department of Public Health (SFDPH) is currently a recipient of the Ryan White HIV/AIDS HIV Emergency Relief Grant Program (Ryan White Programs, Part A) in the amount of $25,640,788 from the Health Resources Services Administration (HRSA). The Part A grant is awarded to the San Francisco Eligible Metropolitan Area which is comprised of the City and County of San Francisco, Marin County, and San Mateo County.

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

Department's Most Recent Draft of Grant Applications Materials

Please see Attachment A for the SFDPH's most recent draft of application materials. SFDPH's most recent application was submitted to HRSA on Oct 18, 2010 for the funding period of March 1, 2011 to February 28, 2012. We have received the application guidance from HRSA for the March 1, 2012 to February 28, 2013 funding period on August 22, 2011 with an application due date of November 1, 2011.

Anticipated Funding Categories

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

Please see Attachment B for an example of the FY2011-12 Planned Service Mode Allocations for the San Francisco EMA. The service modes are defined by HRSA. The San Francisco HIV Health Services Planning Council, a citizen advisory board, is responsible for determining the priorities and the allocation of funds within each HRSA service mode for the San Francisco EMA.

Comments from Relevant Citizen Advisory Board

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

(415) 554-2600 101 Grove Street San Francisco, CA 94102-4593

FY2011-12 Ryan White Part A Grant Program Planned Allocations Report

Allocations Categories	Total FY2011 RWPA Award	
	Amount	Percent
1. Core Medical Services Sub-total [Footnote 1]	**$19,322,896**	**82%**
a. Outpatient /Ambulatory Health Services	$10,511,577	45%
b. AIDS Drug Assistance Program (ADAP) Treatments		--
c. AIDS Pharmaceutical Assistance (local)	$12,158	0%
d. Oral Health Care	$1,055,169	4%
e. Early Intervention Services	$428,780	2%
f. Health Insurance Premium & Cost Sharing Assistance		0%
g. Home Health Care	$679,632	3%
h. Home and Community-based Health Services	$495,618	2%
i. Hospice Services	$1,077,998	5%
j. Mental Health Services	$2,791,638	12%
k. Medical Nutrition Therapy		0%
l. Medical Case Management (including Treatment Adherence)	$2,164,732	9%
m. Substance Abuse Services - outpatient	$105,594	0%
2. Support Services Subtotal	**$4,213,378**	**18%**
a. Case Management (non-Medical)	$616,941	3%
b. Child Care Services	$0	0%
c. Emergency Financial Assistance	$1,052,806	4%
d. Food Bank/Home-Delivered Meals	$665,446	3%
e. Health Education/Risk Reduction		0%
f. Housing Services	$1,062,824	5%
g. Legal Services	$274,995	1%
h. Linguistics Services		0%
i. Medical Transportation Services	$23,315	0%
j. Outreach Services	$258,625	1%
k. Psychosocial Support Services	$192,243	1%
l. Referral for Health Care/Supportive Services	$0	0%
m. Rehabilitation Services		0%
n. Respite Care		0%
o. Substance Abuse Services - residential	$66,183	0%
p. Treatment Adherence Counseling		0%
3. Total Service Dollars	**$23,536,274**	**92%**
4. Clinical Quality Management Activities [Footnote 2]	**$350,000**	**1%**
5. Grantee Administration [Footnote 3]	**$1,754,514**	**7%**
6. Total Allocations [Footnote 4]	**$25,640,788**	**100%**

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

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

(4) Must equal the total FY2010 award.

HIV Health Service Section

Ryan White Part A Planning Council Roster

First Name	Last Name	Notes	Term Expiration
Mark	Agtane	Consumer	8/24/2011
John	Andrews	Consumer	10/8/2011
Margot	Antonetty	Provider [DPH]	2/1/2012
Jeff	Byers	Provider [State of CA]	9/1/2011
Aaron	Chandler	Consumer	2/24/2011
Billie	Cooper	Consumer	10/2/2012
Cicily	Emerson	Provider [Marin]	6/23/2011
Wade	Flores	Consumer	10/30/2011
Liz	Gatewood	Provider [Lyon-Martin]	3/31/2012
Matt	Geltmaker	Provider [San Mateo]	5/31/2011
Chris	Harris	Provider [SF Redevelopment]	3/31/2011
Mary Lawrence	Hicks	Provider [SFGH-Ward 86]	9/2/2012
Carol	Hudson	Consumer	5/31/2011
Lee	Jewell	Consumer	2/28/2012
Billie Jean	Kanios	Community Member	***Pending
Steve	Manley	Consumer	4/30/2011
Rachel	Matillano	Provider	6/23/2011
Matt	Miller	Consumer	3/24/2011
Cathy	Newell	Consumer	5/1/2012
Ken	Pearce	Consumer	9/1/2011
Maritza	Penagos	Provider [MHNC]	12/1/2012
Gerardo	Ramos	Provider [SFAF]	5/31/2011
Michael	Scarce	Consumer	1/25/2012
Stacia	Scherich	Consumer	5/30/2011
George	Simmons	Provider [CYO]	5/24/2012
Charles	Siron	Consumer	3/1/2012
Gwen	Smith	Provider [Southeast]	1/31/2012
Don	Soto	Provider [LSSN]	9/1/2011
Michelle	Spence	Consumer	3/31/2012
Chip	Supanich	Consumer	1/24/2013
Eric	Sutter	Provider [Shanti]	3/31/2012
Lara	Tannenbaum	Provider [Larkin Street Youth]	1/31/2012
Laura	Thomas	Provider [Drug Policy Alliance]	3/1/2012
Channing	Wayne	Consumer	4/27/2012

City and County of San Francisco

Department of Public Health

Edwin Lee
Mayor

Barbara A. Garcia, MPA
Director of Health

October 12, 2011

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

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

Dear Ms. Cavillo:

Attached please find an original and four copies of a proposed resolution for the approval of the Board of Supervisors, which authorizes the San Francisco Department of Public Health (SFDPH) to submit an application for the Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A) to the Health Resources Services Administration (HRSA). This application is required to receive continued funding for the period of March 1, 2012 to February 28, 2013. This application represents approximately $36,118,233 in funding for the San Francisco Eligible Metropolitan Area (EMA). The San Francisco EMA includes the City and County of San Francisco, Marin County and San Mateo County. The funding supports a multitude of health services to HIV positive persons residing in these three counties.

This resolution is required by Ordinance No. 265-05, which amends Section 10-170 of the Administrative Code to require Board of Supervisors review of recurring grant applications of $5,000,000 or more prior to their submission. SFDPH received from HRSA the application guidance on August 22, 2011. The application deadline is November 1, 2011.

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

Sincerely,

Barbara A. Garcia
Director of Health

Enclosures

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

(415) 554-2600 101 Grove Street San Francisco, CA 94102-4593

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

Application for Federal Assistance SF-424

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☐ New	
☒ Application	☒ Continuation	* Other (Specify):
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
Completed by Grants.gov upon submission.	

5a. Federal Entity Identifier:	5b. Federal Award Identifier:
	H89HA00006

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name:	San Francisco Department of Public Health
* b. Employer/Taxpayer Identification Number (EIN/TIN):	94-60000417
* c. Organizational DUNS:	1037173360000

d. Address:

* Street1:	25 Van Ness Ave, Suite 500
Street2:	
* City:	San Francisco
County/Parish:	
* State:	CA: California
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	94102-6012

e. Organizational Unit:

Department Name:	Division Name:

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

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

Title:	Interim Director of HIV Health Services
Organizational Affiliation:	
* Telephone Number:	415-554-9000
Fax Number:	415-431-7547
* Email:	Bill.Blum@sfgov.org

Application for Federal Assistance SF-424

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

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

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

Health Resources & Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.914

CFDA Title:

HIV Emergency Relief Project Grants

*** 12. Funding Opportunity Number:**

HRSA-11-062

* Title:

Ryan White Part A HIV Emergency Relief Grant Program

13. Competition Identification Number:

4254

Title:

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

Add Attachment | Delete Attachment | View Attachment

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

HIV Emergency Relief Grant (Ryan White Programs, Part A)

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

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

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 03/01/2011 * b. End Date: 02/28/2012

18. Estimated Funding ($):

* a. Federal	36,218,233.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	36,218,233.00

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

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

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

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

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

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

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

☒ ** I AGREE

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

Authorized Representative:

Prefix: Ms. * First Name: Barbara

Middle Name:

* Last Name: Garcia

Suffix:

* Title: Deputy Director of Health, Dir of Comm Pgr

* Telephone Number: 415-255-3525 Fax Number:

Email: Barbara.Garcia@sfdph.org

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

EXPANDING THE BENEFITS OF HIV CARE:
SAN FRANCISCO EMA FY 2011 RYAN WHITE PART A
COMPETING CONTINUATION APPLICATION NARRATIVE
TABLE OF CONTENTS

EXPANDING THE BENEFITS OF HIV CARE: SAN FRANCISCO EMA FY 2011 RYAN WHITE PART A COMPETING CONTINUATION APPLICATION NARRATIVE

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

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

1. DEMONSTRATED NEED

Introduction to the San Francisco EMA

Located along the western edge of the San Francisco Bay in Northern California, the San Francisco Eligible Metropolitan Area (EMA) is a unique, diverse, and highly complex region in terms of both geography and demographic diversity. Encompassing three contiguous counties - **Marin County** to the north, **San Francisco County** in the center and **San Mateo County** to the south - the EMA has a total land area of **1,016** square miles, an area roughly the size of Rhode Island. In geographic terms, the EMA is very narrow, stretching more than 75 miles from its northern to southern end, but less than 20 miles at its widest point from east to west. This complicates transportation and service access in the region, especially for those in Marin and San Mateo Counties. In San Mateo County, a mountain range marking the western boundary of the San Andreas Fault bisects the region from north to south, creating further 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 three member counties. While Marin and San Mateo Counties have a land area of **520** and **449** square miles, respectively, San Francisco County covers 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 total 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.

The total population of the San Francisco EMA is estimated by the US Census Bureau at **1,698,282**.[2] This includes a population of **248,742** in Marin County, **744,041** in San Francisco County, and **705,499** in San Mateo County, with widely varying population densities within the three regions. For example, while the population density of Marin County is **479** persons per square mile, the density of San Francisco County is **15,936 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 **1,571** persons per square mile is still ten times lower than its neighbor county to the north. These differences necessitate varying approaches to HIV care in each of the three counties of the EMA.

The geographic diversity of the San Francisco EMA is reflected in the diversity of the people who call the area home. Just under **50%** of the EMA's residents are persons of color, including Asian/Pacific Islander (**23.3%**), Latino (**16.9%**), African American (**5.3%**), and Native American (**0.4%**) populations. In San Francisco, Asian residents make up over **30%** of

the city's total population. The nation's largest population of Chinese Americans lives in the City of San Francisco. It is joined by a diverse range of Asian immigrants, including large numbers of Japanese, Vietnamese, Laotian, and Cambodian residents;. A large number of Latino immigrants also reside in the EMA, including native residents of Mexico, Guatemala, El Salvador, and Nicaragua. EMA-wide, over **40%** of residents speak a language other than English at home - including **46%** of San Francisco residents[3] - with over **100** separate Asian dialects alone spoken in the City. 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.[4] A total of over **20,000** new immigrants join the EMA's population each year, not including as many as **75,000** permanent and semi-permanent undocumented residents.[5]

1.a) HIV/AIDS Epidemiology

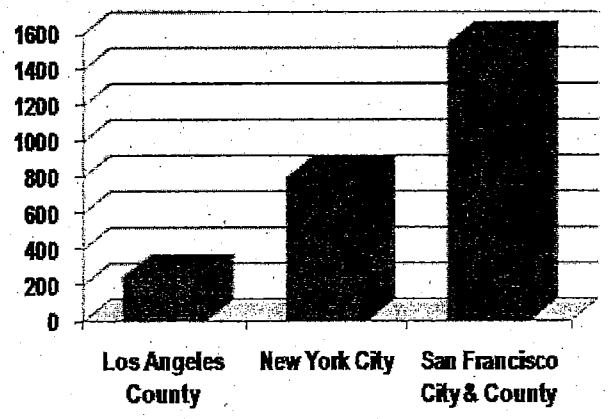
1.a.1) HIV/AIDS Epidemiology Table - See Table in Attachment 3

1.a.2) HIV/AIDS Epidemiology Narrative

Description of Current HIV/AIDS Cases: **More than a quarter century into the HIV epidemic, the three counties of the San Francisco EMA continue to be devastated by the HIV – an ongoing tragedy that has exacted a great human and financial toll on our region.** According to the State of California, as of March 31, 2010, a total of **32,476** cumulative AIDS cases had been diagnosed in the EMA, representing **21%** of all AIDS cases ever diagnosed in the state of California (n=**157,405**).[6] Over **21,000** persons have already died of AIDS in the EMA.[7] As of December 31, 2009, a total of **11,847** persons were living with AIDS in the EMA's three counties while another **12,083** individuals were estimated to be living with HIV, for a total of **23,930** persons estimated to be living with HIV infection in the three-county region as of the end of 2008 (see Table in Attachment 3).[8] This represents an EMA-wide HIV infection incidence of **1,409.1** cases per 100,000 persons, meaning that **more than 1 in every 70 residents of the San Francisco EMA is now living with HIV.** A total of **861** new cases of AIDS were diagnosed in the EMA between January 1, 2008 and December 31, 2009 alone, representing 7.**3%** of all persons living with AIDS at the end of 2009.

At the epicenter of this continuing crisis lies the City and County of San Francisco, the city hardest-hit during the initial years of the AIDS epidemic. **Today, the City of San Francisco continues to have the nation's highest per capita prevalence of cumulative AIDS cases,[9] and AIDS is both the fourth leading cause of death among all male residents age 25-54 and the leading cause of death among Latinos in that age group.**[10] The number of persons living with AIDS in San Francisco has increased by nearly **20%** over the last decade alone - a percentage that does include more rapidly escalating non-AIDS HIV cases.[11] Through December 31, 2009, a cumulative total of **28,409** cases of AIDS have been diagnosed in San Francisco, accounting for nearly **3%** of all AIDS cases ever identified in the US (n=**1,045,457**) and nearly **20%** of all AIDS cases diagnosed in California (n=**155,208**), despite the fact that San Francisco County

Figure 1. People Living with AIDS Per 100,000 Population - Selected US Metropolitan Areas



contains only **2%** of the state's population.[12] As of the end of 2009, an estimated **20,592** San Franciscans were living with AIDS or HIV, representing **86.1%** of all persons living with HIV/AIDS in the EMA, for a staggering citywide prevalence of **2,768** cases of HIV per 100,000. **This means that 1 in every 36 San Francisco residents is now living with HIV disease - an astonishing concentration of HIV infection in a city with a population of only 744,000.** As of December 2009, the incidence of persons living with AIDS per 100,000 in San Francisco County (**1,546.6** per 100,000) was over **five times** that of Los Angeles County (**247.7** per 100,000) and **nearly double** that of New York City (**797.2** per 100,000) (see Figure 1).[13] The following sections provide information on the specific demographics of the local HIV epidemic.

Race / Ethnicity: Reflecting the ethnic diversity of our EMA, the region's HIV/AIDS caseload is distributed among a wide range of ethnic groups. The majority of persons living with HIV and AIDS in the EMA is white (**62.0%**), while **14.2%** of cases are among African Americans; **16.5%** are among Latinos; and **5.1%** are among Asian / Pacific Islanders. A total of **4,453** persons of color were living with AIDS in the San Francisco EMA as of December 31, 2009, representing **37.6%** of all PLWA, while another **4,648** persons of color were estimated to be living with HIV as of the same date (**38.5%** of all PLWHA), for a total of **9,101** persons of color living with HIV/AIDS. **However, the percentage of new AIDS cases among persons of color is increasing rapidly, particularly within Latino and Asian / Pacific Islander communities.** While 37.6% of all people living with AIDS as of December 31, 2009 were persons of color, **nearly half** (**48.8%**) of new AIDS cases diagnosed between January 1, 2008 and December 31, 2009 were among persons of color (n=**420**). Latinos grew from **15.5%** to **16.5%** of all PLWHA living in the EMA between 12/31/08 and 12/31/09, while Asian / Pacific Islanders increased from **4.8%** to **5.1%** of cases over the same period.

Transmission Categories: **The most important distinguishing characteristic of the HIV epidemic in the San Francisco EMA involves the fact that HIV remains primarily a disease of men who have sex with men (MSM).** In other regions of the US, the proportionate impact on MSM has declined over time as other populations such as injection drug users and heterosexuals have been increasingly affected by the epidemic. While these groups have been severely impacted in our region as well, their representation as a proportion of total persons living with HIV and AIDS (PLWHA) has not been as high. Through December 31, 2009, fully **83.1%** of the population of persons living with HIV/AIDS in our region were MSM (**19,884**), including **16,889** men infected with HIV through MSM contact only (**70.6%** of all PLWHA) and **2,995** MSM who also injected drugs (**13.5%** of all PLWHA). This actually represents an increase from the end of 2008, when the percentage stood at **82.3%**. By comparison, only **32.1%** of PLWHA in New York City as of December 31, 2008 were listed as infected through MSM contact.[14] Factors underlying this difference include the high proportion of gay and bisexual men living in the EMA, and the fact that many gay and bisexual men move to San Francisco to receive HIV care and treatment. Other significant local transmission categories include injection drug users (**8.2%** of PLWHA) and non-IDU heterosexuals (**4.2%**). There are signs that this latter population may be increasingly rapidly, however, with **7.3%** of new AIDS cases between January 1, 2008 and December 31, 2009 occurring among non-drug-using heterosexuals (n=**63**).

Gender: Reflecting the high prevalence of HIV/AIDS among men who have sex with men, the vast majority of those living with HIV and AIDS in the San Francisco EMA (**91.2%**) are men. **6.8%** of all PLWHA in the region are women - over **two-thirds** of them (**67.3%**) of them women of color. However, the proportion of women with AIDS in the EMA is steadily increasing, constituting **9.9%** of new AIDS cases diagnosed among women between January 1,

2009 and December 31, 2009, up from **8.6%** during the previous two-year cycle. Because of their high representation within the San Francisco population, **transgender persons** also make up a significant percentage of PLWHA, with at least **496** transgender individuals - the vast majority of them male-to-female – estimated to be living with HIV or AIDS in the EMA as of December 31, 2009, a figure representing **2.0%** of the region's PLWHA caseload.[15]

Current Age:[16] **An increasingly high proportion of persons living with HIV and AIDS in our region are age 50 and above.** This is attributable both to the long history of the HIV/AIDS epidemic in our EMA, resulting in a large proportion of long-term survivors, and the region's hard-fought success in bringing persons with HIV into care and helping them remain on medications, a success that has significantly lengthened the lifespan of many persons with HIV. Among the EMA's combined PLWHA population as of December 31, 2009, **more than two out of every five people living with HIV/AIDS (41.2%)** are age 50 or older, including over **450** PLWHA **age 70 and older. Persons 50 and older now for the first time also make up the majority of persons living with diagnosed AIDS in our EMA, constituting 50.2% of this population as of the end of 2009.** Between December 2007 and December 2009 alone, the number of persons 50 and over living with AIDS increased by **10.9%** within the EMA, while the overall number of PLWA increased by only **2%**. This growing aging population creates new and dramatic challenges for the HIV service system, including the need to develop systems to coordinate and integrate HIV and geriatric care and to plan for potential long-term consequences of HIV drug therapies. The largest proportion of persons living with HIV and AIDS in the EMA remains between the ages of 25 and 49, who make up **57.5%** of the combined PLWHA population, and **72.1%** of new AIDS diagnoses between January 1, 2008 and December 31, 2009. A total of **284** young people between the ages of 13-24 are estimated to be living with HIV/AIDS in the EMA, constituting **1.3%** of the PLWHA population. Only **9** children age 12 and under are estimated to be living with HIV or AIDS in the EMA, and only **2** new AIDS cases were diagnosed among this group between January 1, 2008 and December 31, 2009.

Disproportionate Impact: In terms of ethnic minority representation, both African American and Caucasian populations are **disproportionately affected** by HIV in relation to the overall EMA population, while Latino and Asian/Pacific Islander are **underrepresented** in relation to the general population. Certainly the most dramatic over-representation occurs among **African Americans.** While only **5.3%** of EMA residents are African American, **14.2%** of combined PLWHA populations in the San Francisco EMA are African American, meaning that **nearly three times** the percentage of African Americans are infected with HIV as their proportion in the general population. And while **62.0%** of all PLWHA are white, only **51.2%** of EMA residents are white. By contrast, Asian/Pacific Islanders make up **23.3%** of the EMA's total population, but make up **5.1%** of PLWHA cases while Latinos constitute **16.5%** of PLWA/PLWHA cases but make up **16.9%** of EMA residents. However, new HIV cases will soon create a disproportionate impact among Latinos as well, as in the time frame of January 1, 2008 to December 31, 2009, **19.4%** of newly diagnosed AIDS cases occurred among Latinos.

Homeless and **formerly incarcerated individuals** are significantly over-represented among persons living with HIV and AIDS in our region. While the combined annual EMA-Wide Homelessness Rate is estimated at **1,571** per 100,000, including an estimated **13,500** chronic homeless and another **13,140** individuals who become homeless at some point each year,[17] the combined annual EMA-Wide homelessness rate among persons living with HIV and AIDS is estimated at **7,000** per 100,000[18] - a rate **more than four times** the rate of homeless among the general population. Meanwhile, according to the California Department of Corrections, an

average total of **5,134** persons are held in jail settings **each day** in the San Francisco EMA,[19] while a minimum of **65,000** annual bookings take place in the three-county region.[20] While available reports do not reveal how many of these arrested are among **unduplicated** persons, a conservative estimate based on prevailing recidivism rates would be **17,500** unduplicated individuals arrested and incarcerated each year in the EMA, for an estimated total of **50,000** individuals spending time in incarceration facilities over the past three years - a rate of **3,091** per 100,000. According to data supplied by **Forensic AIDS Project** – the local Center of Excellence serving incarcerated persons - a total of at least **1,023** individuals incarcerated in the San Francisco County jail were HIV-positive and receiving Ryan White services between January 1, 2007 and December 31, 2008 alone, representing **17.9%** of the city's total Ryan White caseload of approximately **5,700** clients as of December 31, 2008, for a three-year incarceration rate of **17,947** per 100,000 – a rate **nearly five times** that of the general population.

The epidemic's most disproportionate impact remains among gay and bisexual men. Approximately **63,577** gay-identified MSM live in the San Francisco EMA,[21] and an estimated **19,884** of them were HIV infected as of December 31, 2009. **This means that a startling 31% of all gay-identified MSM in the San Francisco EMA are already HIV-infected, setting the stage for a continuing health crisis that will impact the future of our region for decades to come.** By contrast, less than **0.4%** of heterosexual men are estimated to be HIV-infected in the San Francisco EMA.

Underrepresented Populations in the Ryan White System: Compared to their proportion of HIV/AIDS cases, **women, persons of color, heterosexuals,** and **transgender people** are **over-represented** in the local Ryan White-funded system, while **whites** and **men** are **underrepresented** in the system of Ryan White-funded services due to higher average incomes and higher rates of private insurance in the latter two groups. For the same reason, MSM are underrepresented among Ryan White clients, even though they make up **76.3% of total Ryan White clients** as of February 28, 2010 . Ryan White clinics provide primary medical care to a population that is disproportionately made up of persons of color, women, persons with low incomes, the homeless, heterosexuals, and injection drug users. Additionally, Part D programs operated by Larkin Street Youth Services and the Family Service Network primarily serve young people and women, while Part C programs operated by the San Francisco Clinic Consortium and Tenderloin Health serve the full spectrum of clients, including the homeless, persons of color, women, and gay/bisexual men. Fully **21.2%** of Ryan White clients in the San Francisco EMA are African American as compared to **14.2%** of all persons with HIV/AIDS in the EMA, while San Francisco's seven **Centers of Excellence** which focus on underserved and hard-to-reach populations serve a population that is **30.6%** African American.[22] Women, representing **6.8%** of the total PLWHA population, make up **10.7%** of Ryan White and **21.7%** of Centers of Excellence clients. Heterosexuals represent **21.5%** of Ryan White clients but only **4.2%** of non-IDU HIV cases. Transgendered people make up an estimated **3.0%** of persons served through the Ryan White system and **5.4%** of persons served through Centers of Excellence while making up **2.1%** of all persons living with HIV and AIDS in the EMA. **All of these statistics highlight the progress the San Francisco EMA has made in reaching and bringing into consistent care the most impoverished and highly underserved HIV-infected residents of the region.**

EMA Service Gaps: According to the recently completed 2008 Unmet Need Framework (see Section 1.g below), a total of **3,654** HIV-aware individuals in the San Francisco EMA are currently **not** receiving HIV primary care, representing **18%** of the region's total estimated HIV-aware population. **This is a dramatic reduction from last year's estimate, in which 5,205**

(23%) HIV-aware individuals were estimated to not be receiving HIV primary care . At least another **5,025** persons with HIV or AIDS are believed to be **unaware** of their status, and are therefore also not receiving HIV care. This means that an estimated **8,679** persons living with HIV/AIDS - roughly **one-third** of the EMA's combined PLWHA population - are out of care. Between March 1, 2009 and February 28, 2010, at least **8,109** individuals were receiving Ryan White-funded services in the EMA, representing an impressive **53.2%** of the region's combined PLWHA population in care, and **33.9%** of the overall PLWHA population.

In 2008, the San Francisco EMA commissioned and completed a **Comprehensive HIV Health Services Needs Assessment**, which included in-depth client surveys completed by **248** PLWHA in all three counties and a series of **4** population-specific focus groups involving monolingual Spanish-speaking persons; persons age 55 and older; Marin County residents; and formerly incarcerated individuals.[23] The Needs Assessment revealed that the local system of care was **extremely successful** in meeting HRSA core service needs among HIV-infected persons who have low incomes, with fully **95%** of survey respondents reporting that their last health care visit for HIV/AIDS had been within the past six months. While the majority of needs assessment respondents stated that they were able to access needed care services, challenges and barriers to health and supportive services that respondents "always" or "sometimes" experience included: a) **transportation** (**12.7%** always / **30.5%** sometimes); b) **service hours** (**6.8%** always / **35.0%** sometimes); c) **cultural sensitivity** (**3.8%** always / **15.3%** sometimes); and d) **language** (**3.0%** always / **9.7%** sometimes). In regard to housing, **21%** of survey respondents met the criteria for being **homeless** - including **4%** living on the streets or in a car - while **12%** of respondents did not have health coverage of any kind.

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

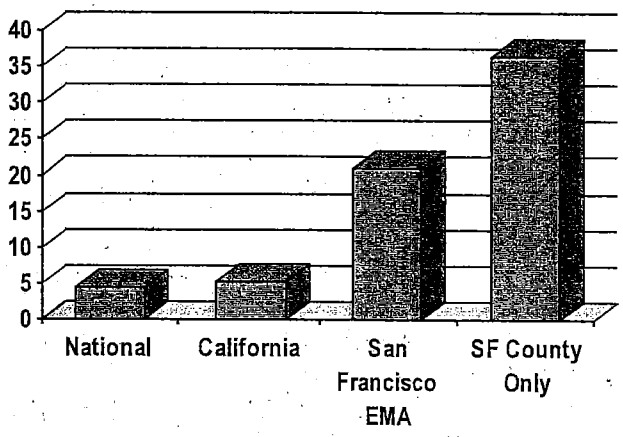
1.b.i) Quantitative Evidence on Co-Morbidities - See Table in Attachment 4

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

Sexually Transmitted Infection (STI) Rates: While San Francisco's per capita HIV infection rates continue to rise, the growing crisis of **sexually transmitted infections** - with San Francisco County frequently having what are by far the highest rates of syphilis and gonorrhea of any county in California is of significant concern for the future of the HIV epidemic in our region. In terms of **syphilis,** for example, the San Francisco EMA continues to confront an ongoing epidemic that has been escalating for the past half decade, **rising more than 500% since 2000.** The total of **334** new primary and secondary syphilis cases diagnosed in the EMA in 2009 represents a significant increase over the 229 cases reported in 2007 and a return to levels near the **364** cases reported in 2004, attesting to a resurgence of the crisis in the region and the difficulty involved in containing or reducing it.[24] Within the City of San Francisco alone, a total of **309** new syphilis cases were reported in 2009, **107 more cases than the 202 cases diagnosed in 2007**, for a **53.0%** increase.[25] The 2009 syphilis incidence rate of **36.3** cases per 100,000 in San Francisco was **6 times higher** than the statewide rate of **5.2** cases per 100,000 and **6 times higher** than the national syphilis rate of **4.5** cases per 100,000 in 2008 (see Figure 2), suggesting continued increases in new HIV infections in the EMA for the foreseeable future.[26] San Francisco County has by far the largest rate of syphilis infections of any county in California, nearly **five times** that of Los Angeles County (**7.4** per 100,000); more than **four times** the rate of San Diego County (**8.1** per 100,000); and roughly **ten times** the rate of Santa Clara County (**3.2** per 100,000).[27]

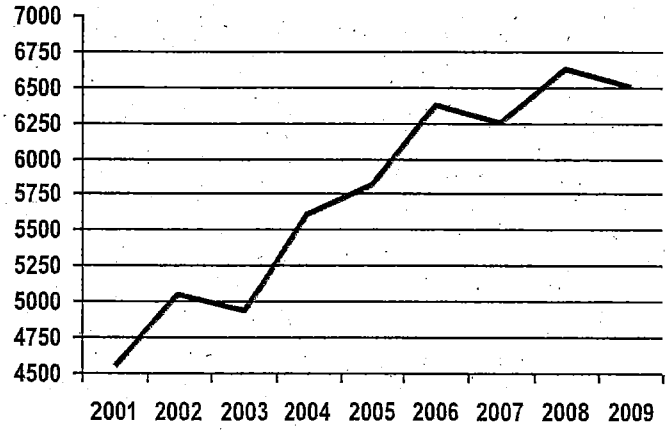
The EMA is also experiencing a significant gonorrhea epidemic. A total of **2.090** new gonorrhea cases were identified in the San Francisco EMA in 2009, for an EMA-wide incidence of **123.1** cases per 100,000, **100% higher** the 2009 California rate of **62.0** cases per 100,000.[28] [29] San Francisco's 2008 gonorrhea incidence of **212.5** cases per 100,000 is **nearly double** the 2008 national rate of **110.3** cases per 100,000 and is **250% higher** than the statewide rate, and is again by far the highest rate of any county in California, with the next highest county – Alameda County - having a case rate **less than half** that of San Francisco (**106.4** per 100,000).[30] Many of the EMA's new gonorrhea cases are occurring among **young women aged 15 – 24,** who accounted for **122** cases in 2009. The gonorrhea rate of **421.3** per 100,000 in 15-24-year-old women in San Francisco is **87% higher** than the statewide rate of **225.9** per 100,000.[31]

Figure 2. 2009 New Primary & Secondary Syphilis Cases Per 100,000 Population



The San Francisco EMA's **Chlamydia** epidemic also continues to rise precipitously, although rates in EMA are much more comparable to national and statewide averages. A total of **6,494** new cases of Chlamydia were diagnosed in the San Francisco EMA in 2009. This represents an **11.7% increase** over the **5,816** cases diagnosed in 2005 and a significant**44%** increase since 2001; although it also represents a slight reduction from the **6,627** cases identified in the EMA in 2008 (see Figure 3).[32] The 2009 EMA-wide Chlamydia incidence stood at **382.4** per 100,000, while the rate for the City of San Francisco was **490.2** cases per 100,000.[33] By comparison, the 2009 incidence for California was **380.6** cases per 100,000.[34]

Figure 3. Annual Reported Chlamydia Cases - San Francisco EMA - 2001-2009



The cost of treating STIs adds significantly to the cost of HIV care in the San Francisco EMA. According to a study which estimated the direct medical cost of STIs among American youth, the total cost of the **9 million** new STI cases occurring among 15-24 year olds totaled **$6.5 billion** in the year 2000 alone, at a per capita cost of **$7,220 per person.**[35] Lissovoy, et al. estimated 1990 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.[36] A study

published in the *American Journal of Public Health* estimated that in 2000, a total of **545** new cases of HIV infection among African Americans could be attributed to the **facilitative effects of infectious syphilis**, at a cost of about **$113 million**, or a per capita cost of **$20,730.**[37] Such studies suggest that the total cost of treating new STIs in the SF EMA may be as high as **$12.0 million** per year, including an estimated **$2.97 million** to treat STIs among persons with HIV, with another **$75 million** in costs potentially resulting from the need to treat persons infected with HIV as a result of transmission facilitated through other STIs.[38]

Housing and Homelessness: Housing is an indispensable link in the chain of care for persons with HIV. Without adequate, stable housing it is virtually impossible for individuals to access primary care; begin and maintain combination therapy; and preserve overall health and wellness. These issues are more critical for persons with co-morbidities such as substance addiction or mental illness, since maintaining sobriety and medication adherence is much more difficult without stable housing. Homelessness is also a critical risk factor for HIV itself, with one national study reporting one or more HIV risk factors among **69%** of homeless persons.[39]

Because of the prohibitively high cost of housing in the San Francisco EMA and the shortage of affordable rental units, the problem of homelessness has reached crisis proportions, creating formidable challenges for organizations seeking to serve HIV-infected populations. According to the National Low Income Housing Coalition's *Out of Reach 2010* report, Marin, San Francisco, and San Mateo Counties – the three counties that make up the San Francisco EMA – are **tied with one another** as the **three least affordable counties in the nation** in terms of the hourly wage needed to rent a two-bedroom apartment, which currently stands at **$33.85 per hour** (see Figure 4).[41] Meanwhile, the San Francisco Metropolitan Area has the **highest HUD-established Fair Market Rental rate in the nation**, representing the amount needed to "pay the gross rent (shelter plus utilities) of privately owned, decent, and safe rental housing of a modest (non-luxury) nature with suitable amenities".[42]

Figure 4.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs, 2010[40]

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

On January 27, 2009, the City of San Francisco conducted its bi-annual 24-hour homeless count which identified a total of **6,514** homeless men and women living on the streets or in jails, shelters, rehabilitation centers, or other emergency facilities, an increase of **2%** over the 2007 total of **6,377**.[43] San Francisco also serves an additional **3,000 - 7,000** temporarily homeless individuals per year, which means that - with anywhere from **11,640** to **15,640** homeless per year - the city has the **second highest per capita homelessness rate of any city in the U.S.**[44] A recent study by the University of California San Francisco found that the City's chronic homeless population has also continued to age, with a current median age among these groups estimated at **50** - up from **37** years of age when population studies first began in 1990.[45] Aging

augments the progression of chronic diseases related to homelessness, including high rates of diabetes and hypertension, and complicates the problem of providing care to these groups. Combining data for San Francisco, Marin, and San Mateo counties, it is estimated that **26,640** individuals experience homelessness at some point during the year in the EMA, including an estimated **13,500** chronically homeless individuals and **13,140** temporarily homeless persons.

Homelessness has a distinct and well-established link to HIV disease. HIV prevalence studies among homeless adults in San Francisco have produced estimates ranging from a **9%** HIV prevalence rate among the general homeless adult population[46] to an astounding **41%** among marginally housed adult MSM.[47] Among the hundreds and possibly thousands of homeless youth in San Francisco - a city which still serves as a Mecca for runaway and low-income young people - estimated HIV prevalence ranges from **29%** among young homeless gay and bisexual males[48] to **68%** among gay and bisexual male teens who enter homeless youth centers.[49] **HIV disease itself also frequently results in homelessness, with the percentage of persons who were homeless at the time of AIDS diagnosis increasing in the City of San Francisco from 3% in 1992 to 11% in 2007, a nearly fourfold increase.**[50]

The burden of **costs** that homelessness places on the local system of care is difficult to calculate, but adds significantly to the price of HIV/AIDS care. A study by the San Francisco Department of Public Health Housing and Urban Health Division found that the annual cost of medical care for homeless men and women averaged **$21,000** for inpatient, emergency department, and skilled nursing facility care, a figure which decreased to an average **$4,000** per year for individuals placed in permanent subsidized housing.[51] Meanwhile, a two-year University of Texas survey of homeless individuals found that the public cost of caring for the homeless averaged **$14,480** per person per year, primarily for overnight jail stays.[52] Overall, SF DPH estimates that the total costs of homelessness add at least an additional **$16.9 million** to the cost of care for HIV-positive individuals within the EMA – costs that do not take into account the higher rates of HIV infection among homeless populations.[53]

Insurance Coverage: According to just-published data from the UCLA Center for Health Policy Research, an estimated **11.1%** of San Francisco EMA residents under the age of 65 are believed to be without **any** form of insurance coverage - including Medicaid - for a total of at least **188,772** uninsured individuals under 65 in our region (persons 65 and older are excluded as they become eligible for age-based Medicare).[54] This includes an estimated **13.4%** uninsured in San Francisco; **10.8%** uninsured in San Mateo County; and **14.1%** uninsured in Marin County.[55] **The lack of health insurance is a significant barrier to care, placing extreme financial burden on the system, particularly in the San Francisco EMA, which has extremely high medical costs.** In addition, because of the current financial crisis, the numbers of persons who have lost private insurance as a result of unemployment or reduced employment based health insurance benefits has dramatically increased the number of uninsured persons in the State over the past two years. According to 2009 data, **49.5%** of San Francisco Ryan White system clients were covered by Medicaid, but **25.1%** lacked **any** form of insurance coverage. At the same time, for those persons with HIV not in care or unaware of their HIV status, the uninsured rate is believed to be much higher than the general population as many HIV-infected people in the EMA are disproportionately poor, not in care, and/or have not yet applied for Medicaid. SF DPH estimates that the **cost** to the system of serving uninsured and indigent populations living with HIV is at least **$85.6 million** annually, based on an average **25.1%** uninsured rate among persons living with HIV/AIDS in care (n=**4,279**) at an estimated annual average cost of **$20,000** per person for HIV treatment and medications. However, the overall picture for the uninsured in San

Francisco has begun to change. The city is currently engaged in the nationally recognized initiative **Healthy San Francisco**, designed to ensure universal health care access to the city's estimated **82,000** uninsured. The EMA will continue to track the ongoing impact of this program on both access and quality of care for PLWHA in the region.

Poverty: The problem of homelessness is closely tied to that of **poverty**, and presents another daunting challenge to the HIV care system. Using poverty data from the 2000 Census updated to 2006 population estimates, SF DPH projects that **810,420** individuals in the San Francisco EMA are living at or below 300% of Federal Poverty Level, which translates to **47.7%** of the overall EMA population lacking resources to cover all but the most basic expenses.[56] **However, because of the high cost of living in the San Francisco Bay Area, persons at 300% of poverty or below have a much more difficult time surviving in our area than those living at these income levels in other parts of the U.S.** Analyzing data from the San Francisco AIDS Regional Information and Evaluation System (ARIES),the SF EMA's client-level data system, it is estimated that at least **65.4%** of all persons living with HIV/ AIDS in the San Francisco EMA (n=**15,656**) are living at or below 300% of the 2009 Federal Poverty Level (FPL) including persons in impoverished households. **100%** of Ryan White-funded clients live at or below 300% of poverty.[57] ARIES data reveals that **40%** of active Ryan White clients in San Francisco are currently living on incomes of **less than $10,000 per year** and **17%** are surviving on incomes of less than $5,000 per year. HIV-infected persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **$108 million** in Part A and non-Part A HIV-related expenditures in the San Francisco EMA each year.[58]

1.b.iii) Impact of Recently Incarcerated Individuals

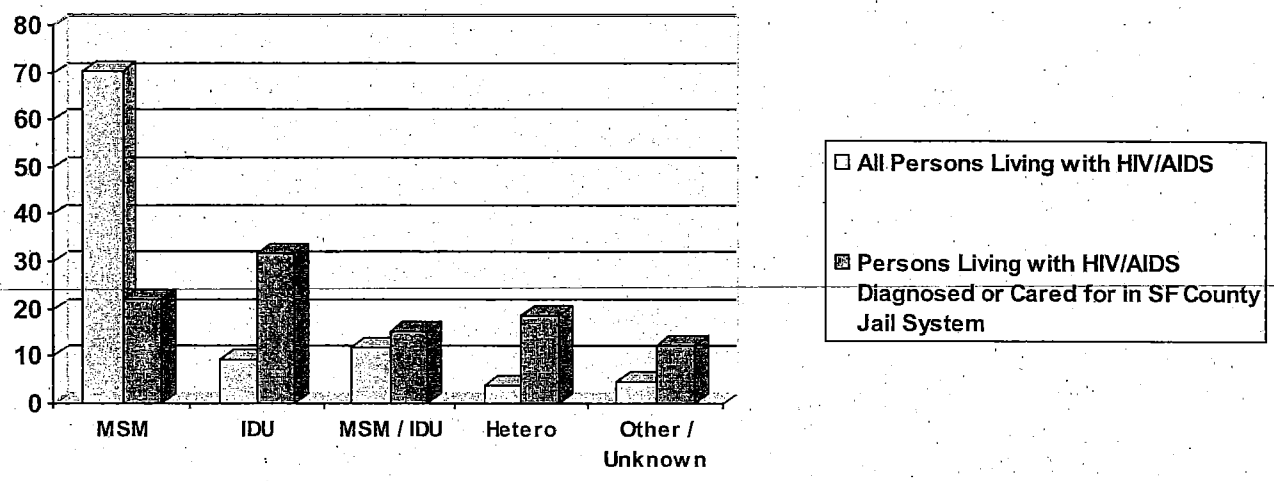
The San Francisco EMA HIV care system provides services to a large number of formerly incarcerated individuals whose significant needs pose additional challenges.. As noted above, the California Department of Corrections reports that an average total of **5,134** persons are held in jail settings each day in the San Francisco EMA, while a minimum of **65,000** annual bookings take place in the three-county region. Data from Forensic AIDS Project shows that a total of at least **1,023** formerly incarcerated individuals received Ryan White services at the agency over the three-year period between January 1, 2006 and December 31, 2008, representing approximately **18.6%** of the City's total Ryan White-funded caseload of approximately **5,500** persons. This represents a three-year past incarceration rate of **18,600** per 100,000 – a rate **more than four times** that of the general population. Transitions between the community and incarceration often greatly impact an individual's ability to access and remain in HIV care and treatment, and to stabilize life circumstances that promote wellness.

The San Francisco EMA is also home to **San Quentin State Prison**, California's oldest and largest prison. Opened in 1852, the prison houses an average daily population of **5,222** inmates in facilities originally designed to house 3,317 individuals. The prison also serves as the identification point for a large number of persons with HIV, many of whom are paroled to the Bay Area and seek HIV services following release. Over the three calendar years from January 1, 2004 to December 31, 2006 a total of **51** persons were diagnosed with HIV at San Quentin Prison, including **46** male and **5** transgender individuals. Nearly **one-third** of these (**29%**) were infected through injection drug use alone, as compared to **9%** of all persons living with HIV/AIDS in the EMA. **African Americans** are highly overrepresented among the San Quentin HIV population, representing **45%** of all HIV cases diagnosed in the facility from 2004 to 2006.

An analysis of epidemiological and client data reveals a range of factors that are strongly associated with significantly increased cost and complexity of care for formerly incarcerated

populations with HIV in the Bay Area. For example, of the **1,023** HIV-positive individuals served by Forensic AIDS Project and released from SF jails in the three years through December 31, 2008, **13.6%** were **women – double** the percentage of women living with HIV/AIDS in the EMA as of that date (**6.8%**) – and **5.4%** were **transgender persons – more than three times** their representation among the EMA's total PLWHA population (**2.0%**). Reflecting high rates of injection drug use among incarcerated populations, **31.9%** of persons with HIV in the SF jail system had been infected through injection drug use alone, as compared to **9.2%** of the overall PLWHA population, while MSM / IDU cases accounted for **15.4%** of jail populations, versus **12.0%** within the total PLWHA population (see Figure 5). These findings are mirrored in a recent study of young injectors under age 30 in San Francisco, which found that **86%** had a lifetime history of incarceration; **56%** had been incarcerated in the past year; and **42%** were infected with hepatitis C – a critical marker of potential HIV infection.[59] Equally alarming is the over-representation by **African Americans** among formerly incarcerated persons with HIV in SF, who account for **43.8%** of all PLWHA diagnosed with HIV or provided with HIV care in

Figure 5. Comparison of Overall PLWHA Population with PLWHA Population Diagnosed / Cared For in SF County Jail System as of 12/31/08 by Transmission Category



San Francisco jails, despite making up **14.8%** of the total PLWHA population.

Within the San Francisco EMA the crisis of HIV among incarcerated and formerly incarcerated populations has long been responded to with specific and focused responses to meet the needs of these populations. Objective # 4.4 of the EMA's new 2009-2012 Comprehensive Plan specifically calls on the local system to "continue to develop systems and partnerships that ensure that persons who are in prison or incarcerated are fully linked to care upon their release from the jail and prison systems." When the EMA created its nationally recognized Centers of HIV Excellence program in November 2005, one of the seven new centers funded was **Forensic AIDS Project** – a one-stop-shop comprehensive care center coordinated by the San Francisco Health Department, providing jail-based health services and post-release treatment and care linkage services to incarcerated persons with HIV. Forensic AIDS Project offers screening, support, and medical case management services for the majority of known HIV-infected individuals leaving the San Francisco jail system, and ensures a smooth transition in terms of both medical care and social services.

The precise burden of **costs** related to the high rates of recent incarceration among PLWHA populations in the San Francisco EMA is difficult to calculate. However, demographic characteristics of this population – including a higher percentage of women and transgender persons with low incomes; greater representation by African Americans with low incomes; and higher rates of injection drug use – point to indicators of severe need requiring specialized support and assistance that significantly increase our region's cost of HIV care. Annual services by Forensic AIDS Project, for example, are currently budgeted at **$346,558** per year, a figure that includes only immediate post-release care and service linkage. Additional costs related to higher rates of HIV infection related to incarceration itself, coupled with long-term costs of care and treatment for individuals with low incomes and persons with issues of substance use, may total at least **$1.23 million** per year in additional direct incarceration-related HIV expenditures for the San Francisco EMA.[60]

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

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

1.c.ii) Coordination of Services and Funding Streams

Coordination with Other Federal and State Resources: The San Francisco HIV Health Services Planning Council and the SF Department of Public Health work together to ensure that Ryan White Part A funds are fully coordinated with all applicable funding streams in the region, and to ensure that Part A funds are only utilized if no other source of funding is available. As with the Ryan White streams listed above, the Planning Council receives annual service category summaries that include a detailed listing of all non-Ryan White funding streams for each category, including sources such as State matching funds for 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 works to ensure that services are coordinated to maximize the number and accessibility of services, while seeking every possible alternate source of funding apart from Part A to support HIV care.

Probably the most important complementary funding stream to support HIV care for populations with low incomes is the **Medicaid** system, or **Medi-Cal**, as the system is known in California. Medi-Cal serves as an indispensable link in the chain of support for persons with low-incomes and HIV in the San Francisco EMA. In documents provided by the State of California for this year's Part A application, a total of **$91,236,172** in HIV-specific Medi-Cal expenditures were reported for the three counties of the San Francisco EMA for the 12-month period from July 1, 2009 – June 30, 2010.[61] Nearly **one-half (49.4%)** of HIV Medi-Cal expenditures in the San Francisco EMA over this 12-month period were for **HIV-related medications ($45,084,342)**; another **16.7% ($15,262,570)** were for **inpatient care**; and **15.9% ($14,514,056)** were for **intensive and skilled nursing care.**[62] The remaining **18.0%** were dispersed among other categories. A total of **5,892** unduplicated HIV-positive individuals were listed as Medi-Cal recipients for the period January 1 – July 31, 2010, an increase of **7.3%** over the 5,491 beneficiaries reported two years ago, and an indication of how the growing state budget crisis is impacting income levels and insurance status among persons living with HIV/AIDS.

The San Francisco HIV Health Services Planning Council examines changes in Medi-Cal data each year and takes this information into consideration in making its annual allocation of Part A primary medical care funding. The Council considers a wide range of counterbalancing

factors, such as the proportion of persons newly enrolled in Medi-Cal to the number of new annual HIV cases, and the extent to which the growth in recent immigrant and other non-Medicaid-eligible low-income populations may be outpacing the growth in Medi-Cal enrollments and reimbursements. The Council also explores the extent to which reduced Medi-Cal reimbursements in California are driving local providers out of care, and increasing the difficulty even Medicaid-enrolled individuals sometimes have in accessing care.

Among the most significant additional non-Ryan White funding streams which affect the allocation of Part A resources and determine the region's overall level of care include the following:

- The **AIDS Drug Assistance Program (ADAP)** provides a major source of income for HIV care in California, supporting the costs of a diverse formulary for tens of thousands of low-income California residents. According to NASTAD's 2010 National ADAP Monitoring Report, total ADAP expenditures in California in calendar year 2009 totaled **$412,032,756,** by far the largest ADAP budget in the nation and **64%** more than the next highest state, New York, at $257,258,973.[63] At the same time, California's state contribution to the program totaled **$70,859,000**, also by far the largest contribution by any state in the nation, making up **17%** of total ADAP contributions. Over **23,000** Californians were enrolled in ADAP as of June 2009, versus 14,399 for the state of New York, the next highest state.[64] While California has continually demonstrated its unwavering support for ADAP – most recently in the 2010-2011 State budget passed just a few days before this writing – the future of ADAP is far from certain. While the scale of California's ADAP population and contribution attests to success in and commitment to enrolling and retaining low-income persons with HIV in care, it is also clear that even a slight funding reduction would have drastic consequences for the tens of thousands of individuals who rely on this funding to keep them alive.
- Veterans in the EMA are able to access care at **three Veterans Administration (VA)** clinics in the EMA: the Infectious Diseases Clinic at the San Francisco VA Medical Center, offering primary medical care to PLWHA along with access to clinical trials and research; the VA outpatient clinic in the South of Market area in San Francisco; and the Palo Alto VA Center located just outside the EMA, with a satellite clinic in Menlo Park in San Mateo County which is co-located with a public Part A-funded clinic.
- **Housing Opportunities for Persons with AIDS (HOPWA)** services are coordinated through the HOPWA Loan Committee, which includes two Planning Council representatives. For FY 2010, the total HOPWA allocation for the San Francisco EMA totals **$9,977,748**, including **$8,756,448** for San Francisco County; **$871,100** for San Mateo County; and **$350,200** for Marin County. The Grantee works closely with the San Francisco Redevelopment Agency, which administers HOPWA funds, to coordinate housing access for Ryan White Part A-funded clients.
- Other state and local social services programs, such as **General Assistance** and **vocational rehabilitation programs** are used by PLWHA in the EMA. General Assistance provides a very small amount of money per month, less than the average SRO hotel rent. Vocational services including counseling, training, and job placement are provided directly to PLWHA who wish to enter or re-enter the workplace.
- **Substance abuse services** are supported through a combination of federal, state, local, and private funds, with each county combining resources together to develop its own local system. The passage of California Proposition 36, requiring drug treatment rather than incarceration for many persons convicted of drug-related offenses, significantly increased

funds available for substance abuse treatment in the EMA. However, funding for Proposition 36 was eliminated by the Governor in last year's budget, and local governments cannot fill this gap. The EMA has therefore lost a major source of support for substance abuse treatment services. California also receives HIV set-aside funds from **SAMHSA**, which are primarily used to provide HIV counseling and testing within substance abuse treatment programs.

Coordination with Other Ryan White Act Programs: The San Francisco EMA is dedicated to ensuring the integration and coordination of **all** sources of Ryan White funding in the region. The San Francisco HIV Health Services Planning Council prioritizes the use of Ryan White funds for services that are not adequately funded through other reimbursement streams in order to ensure that Part A funds are the funding source of last resort. During each year's priority setting and allocation process, the Grantee produces detailed fact sheets on each service category that include a listing of **all** other funding streams available for that category, including Part B, C, D, and F programs, ADAP, and MAI funding. The San Francisco Planning Council also assists in the planning for Part B-funded services. The Planning Council works with other local planning groups such as the HIV Prevention Planning Council and Long Term Care Coordinating Council to coordinate services and eliminate duplication. The figure below details the specific complementary Ryan White contributions received in the San Francisco EMA during the most recent 12-month contract period for each category (see Figure 6).

Figure 6. Table of Complementary Ryan White Funding – San Francisco EMA Most Recently Completed 12-Month Funding Cycles

Local Jurisdictions	Ryan White Funding Categories & Amounts					H.U.D. Funding
	MAI	Part B	Part C	Part D	Part F	HOPWA
San Francisco County	$ 704,423	$ 3,404,674	$ 1,221,810	$ 1,104,879	$ 1,480,000	$ 8,756,448
San Mateo County	0	$ 331,180	0	0	0	$ 871,100
Marin County	0	$ 166.399	0	0	0	$ 350,200
TOTAL	$ 704,423	$ 3,902,253	$ 1,221,810	$ 1,104,879	$ 1,480,000	$ 9,977,748

1.d) Assessment of Populations with Emerging Needs

As a region with a high degree of diversity and complexity in which new cases of HIV continue to proliferate, the San Francisco EMA is home to a wide range of populations with emerging needs, including women, youth, and transgender people; members of distinct ethnic, cultural, and linguistic groups; homeless and formerly incarcerated persons; and members of diverse social and behavioral communities. These groups require specialized interventions to initially link and then retain them in care; meet their service needs; and empower them to become their own care self-advocates. **The challenge of effectively meeting the needs of emerging populations in the context of declining resources and a shrinking network of**

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

Figure 7.
Persons Living with Diagnosed HIV or AIDS Age 50 and Above in San Francisco as of 12/31/09

Demographic Categories	Number	Percent
Gender		
Male	7,792	92.9%
Female	470	5.6%
Transgender	126	1.5%
Current Age		
50 – 54 Years	3,476	41.4%
55 – 59 Years	2,596	31.0%
60 – 64 Years	1,360	16.2%
65 – 69 Years	608	7.3%
70 – 74 Years	220	2.6%
75 – 79 Years	79	0.9%
Age 80 and Above	49	0.6%
Ethnicity		
White	5,843	69.7%
African American	1,298	15.5%
Latino	854	10.2%
Asian / Pacific Islander	255	3.0%
Other / Unknown	138	1.6%
Transmission Categories		
MSM	6,274	74.8%
Injection Drug Users	733	8.7%
MSM Injection Drug Users	919	11.0%
Non-IDU Heterosexuals	209	2.5%
Other / Unidentified	253	3.0%
TOTAL	**8,388**	**100.0%**

Emerging Population # 1: Persons With HIV Over 50 Years of Age: In part because it was one of the regions hardest hit by the HIV crisis in the early 1980s, and in part because of success in ensuring that a large proportion of persons with HIV have access to the high quality treatments and therapies, the HIV-infected population of the San Francisco EMA continues to age dramatically, at levels beyond which could have been imagined in the first decade of the epidemic. **As of December 31, 2009, more than two out of every five persons living with HIV and AIDS in the San Francisco EMA (41.2%) were 50 years of age and over (9,851 persons) while for the first time the percentage of persons 50 and older living with AIDS exceeded half of all PLWA in the EMA (5,950 out of 11,847 persons / 50.2%).** An analysis conducted for this application of the **5,300** persons age 50 and above living with confirmed AIDS and HIV as of December 31, 2009 (see Figure 7) revealed many startling facts about this population, including the fact that there are **49 persons age 80 and above** living with HIV in the EMA, along with **299** HIV-infected individuals **between the ages of 70 and 79.**

The 50 and over population also contained a slightly higher percentage of African Americans than in the PLWHA population as a whole (**15.5%** vs. **14.2%**), along with a slightly lower percentage of women (**5.6%** vs. **6.8%**). Because HIV medications are still relatively new, it is not yet known either what the long-term effects of long-term therapy use will be on older persons with HIV or how traditional health issues related to aging and geriatric health may interact with or complicate HIV treatment and care. Aging populations will certainly present

challenges to the health care system in terms of devising new strategies for providing integrated HIV and geriatric care, and for meeting the long-term needs of clients with increasingly complex needs. At the same time as a result of previous employment, many older long-term survivors living with HIV/AIDS who have had the advantage of long-term disability policies will lose those benefits immediately upon reaching Social Security retirement age and may find themselves immediately in poverty, a problem with which the current system is unprepared to deal . The annual **cost** of providing HIV-related services to persons over 50 years of age is estimated to be as high as **$157,600,000**.[65]

Emerging Population # 2: Transgender Persons: Transgender persons are traditionally defined as those whose gender identity, expression, or behavior is not traditionally associated with their birth sex. Some transgender individuals experience gender identity as being incongruent with their anatomical sex and may seek some degree of sexual reassignment surgery, take hormones, or undergo other cosmetic procedures. Others may pursue gender expression (whether masculine or feminine) through external self-presentation and behaviors. Key HIV risk behaviors among transgender persons include **multiple sex partners**, **irregular condom use**, and **unsafe injection practices** stemming both from drug use and from the injection of hormones and silicone.[66] Because of the region's traditional openness to diverse lifestyles, many transgender individuals move to the San Francisco EMA seeking greater acceptance and an expanded sense of community. According to Clements, at least **5,000** transgender persons call the Bay Area home, although precise statistics are not available.[67] What is not in question, however, is the epidemic's growing impact on these populations. As of December 31, 2009, at least **500** transgender persons were living with HIV and AIDS in San Francisco and Marin Counties (the County of San Mateo does not break out transgender HIV cases separately). The actual numbers, however, are probably much higher, with some studies indicating that HIV infection rates may be as high as **23.8%** among this population, which in San Francisco would mean that at least **1,200** transgender persons may already be living with HIV.[68] In San Francisco, transgender persons with HIV overwhelmingly identified as having been infected through MSM sexual contact with men (**97.2%**), although many MTF clients living with HIV have undergone sexual reassignment surgery and identify as having been women infected through heterosexual contact. Reflecting high rates of unsafe injection practices within this population, **45.2%** of local transgender PLWHA were infected through MSM contact **and** unsafe injection practices, a percentage **32.9% higher** than among all PLWHA. Persons of color make up nearly **two-thirds** of all transgender PLWHA in San Francisco, with African Americans constituting **38.0%** of transgender PLWHA and Latinos making up another **24.6%**, The San Francisco transgender population is also young, with persons between the ages of 18 and 29 making up **36%** of all transgender AIDS cases diagnosed in 2007-2008. Because of culturally-defined dichotomous gender roles, transgender persons face **widespread stigma and discrimination** which can create significant barriers to HIV care. Transgender-related stigma is associated with **lower self-esteem, increased likelihood of substance abuse** and a high prevalence of **survival sex work**, particularly among MTFs.[69] **Social marginalization** resulting from discrimination can result in the denial of educational, employment, and housing opportunities to transgender persons, factors that can reduce utilization of health services by forcing individuals to focus on **survival issues**. Transgender persons also frequently lack access to health services due to low socioeconomic status, lack of insurance, fear of transgender status being revealed, and a lack of provider sensitivity and expertise with these populations. Because of high rates of poverty, transgender persons are disproportionately dependent on the Ryan White system of care to help support core

medical services. The annual **cost** of providing HIV-related services to transgender persons in the San Francisco EMA is estimated to be at least **$5,625,000** per year.[70]

Emerging Population # 3: Men of Color Who Have Sex with Men (MSM): MSM make up by far the most heavily HIV-impacted population in the San Francisco EMA, accounting for **83.1%** of all persons living with HIV and AIDS as of December 31, 2009, including MSM who inject drugs (n=**19,884**). At least **6,000** of these individuals - or **31%** of the HIV-infected MSM population of the EMA - are people of color, most of them **African Americans** and **Latinos**. However, in calendar year 2009, nearly half of all persons who tested positive for HIV (**48.0%**) were persons of color, an increase of **13.4%** from 2006. Within Latino communities EMA-wide, MSM make up **81.7%** of all persons living with HIV/AIDS, including **72.6%** infected through MSM contact and **9.1%** infected through MSM contact and injection drug use. Among Asian and Pacific Islander groups, the percentage is even higher, with MSM accounting for **79.3%** of all persons living with HIV/AIDS, including **74.7%** MSM only cases and **6.0%** MSM/IDU cases. The percentage of MSM cases among African Americans is somewhat lower, largely due to the fact that a much higher proportion of African Americans living with HIV and AIDS are women. MSM of color in the San Francisco EMA tend to be poorer; have less access to preventive health care; have lower rates of private insurance; and have higher levels of co-morbidities. MSM of color are also believed to have significantly higher levels of unmet need than white MSM. Prior needs assessments have found that perceived **structural barriers,** such as restrictive or complex rules for entering service, and perceived **lack of service access** were cited most frequently as barriers to care for MSM of color, with more than **half** of assessment respondents saying they were likely to have a problem related to these factors. Lack of insurance; the high cost of care; not knowing services are available; and perceived lack of confidentiality were cited as particular barriers to care among MSM who reported being out of care **for a year or more**. The annual **cost** of providing HIV-related services to men of color who have sex with men is estimated at **$102,345,000**.[71]

Emerging Population # 4: Homeless Individuals: Homelessness is an ongoing crisis for the San Francisco EMA, contributing to high rates of HIV infection, and creating an intensive need for integrated, tailored services which bring homeless individuals into care, stabilize their life circumstances, and retain them in treatment. At least **1,691** HIV-infected homeless individuals are estimated to be living with HIV or AIDS in the San Francisco EMA each year (based on an overall 7% homelessness rate among PLWHA), and at least **42%** of them are estimated to be out of care. Because of their disconnection from health and social service systems, homeless individuals are the population **least likely** to obtain regular health or preventive care. **Clearly, the most pressing immediate service need for HIV-infected homeless people is to obtain safe, stable housing that allows them to enter care and to remain adherent with HIV medication regimens.** However, the scarcity of housing resources in the EMA makes it difficult for HIV-infected homeless people to obtain housing quickly, and many homeless individuals are lost to care while waiting for housing slots to become available. All current housing waiting lists in San Francisco are closed, while the average waiting time for those already on the list is **10 years.** Rates of mental illness and substance addiction are also disproportionately high among the homeless, complicating both outreach and care provision, and necessitating integrated service programs such as the Centers of Excellence initiative. The annual **cost** of providing HIV-related services to homeless individuals is estimated at **$31,580,000**.[72]

Emerging Population # 5: African Americans: The growing crisis of HIV among African Americans in the San Francisco EMA is a cause for significant concern. As of December

31, 2008, a total of **3,402** African Americans were estimated to be living with HIV/AIDS in the EMA, representing **14.2%** of the region's HIV-infected population, despite the fact that only **5.3%** of the EMA's population is African American. At the same time, fully **19.4%** of all those diagnosed with AIDS between January 1, 2008 and December 31, 2009 were African American – a percentage **36.6%** higher than their representation in the overall PLWHA population. At least **35%** of all African Americans living with HIV in the San Francisco EMA are currently estimated to be out of care - a proportion comparable to the percentage of homeless persons out of care. The reasons for this under-representation include: a) continuing high rates of stigma within African American communities related both to HIV and the behaviors that transmit it; b) higher prevailing rates of poverty and unemployment, leading to lower rates of private insurance and health care utilization; and c) high rates of injection drug use and homelessness, leading to difficulty in accessing or prioritizing care. Of the 183 African Americans surveyed for the EMA's 2008 Needs Assessment, **49.3%** reported having no insurance of any kind, and **53.3%** reported a high or complete disconnection from care, with frequently cited barriers including: fear of governmental health services; lack of culturally competent services; racial discrimination; frustration with long waiting lists; and a lower prioritization of health care due to competing needs driven by poverty and racism. In order to successfully reach more HIV-infected African Americans, the local care system has had to engage in a more aggressive and comprehensive approach by locating culturally appropriate services within historically black neighborhoods to inform African Americans of the importance of HIV testing and proactively engaging them in treatment. **The Southeast Partnership for Health – a Center of Excellence created in the Bayview-Hunters Point neighborhood – and the Southeast Health Center, both supported with Ryan White Part A funds, are making a significant contribution toward addressing this discrepancy.** The annual **cost** of providing HIV-related services to African Americans is estimated at **$41,634,000**.[73]

Emerging Population # 6: Latinos: In the San Francisco EMA, the Latino population makes up a rapidly growing percentage of the region's total HIV-infected population. While **16.5%** of those estimated to be living with HIV and AIDS as of December 31, 2009 were Latino/a, **19.4%** of new AIDS cases diagnosed between January 1, 2008 and December 31, 2009 were among Latino/as, with a total of **3,931** Latino/a PLWHA estimated to be living in the EMA as of the end of 2009 – a dramatic **5%** increase over the **3,735** estimated PLWHA in 2008. According to the most recent San Francisco HIV Epidemiology Report, Latinos represent **31%** of young adult AIDS cases age 20-24 in the city and an alarming **44%** of adolescent AIDS cases age 13-19 in the city – a clear overrepresentation when compared to the **23%** of the general adolescent population of San Francisco which is Latino/a. As with African American populations, a lack of access to health care, higher rates of poverty and unemployment, and a disconnection from health and social services contribute to relatively high rates of unmet need in the Latino population. According to the US Census, in the City of San Francisco, **11.1%** of the city's population speaks Spanish as their primary language, with **26.5%** of those who speak Spanish as their primary language reporting they speak English either not well or not at all. This requires that HIV services be provided in Spanish throughout the EMA by culturally competent professionals who understand the health beliefs and practices of Latino communities. Fear of jeopardizing naturalization opportunities also leads to a reluctance to seek HIV testing or treatment. The **Mission Center of Excellence** operated by Mission Neighborhood Health Center and funded through Minority AIDS Initiative funding provides culturally competent, integrated, bilingual/bi-cultural HIV services to over **400** Mission neighborhood residents, with an emphasis

on Spanish-speaking Latino clients, in order to enhance their quality of life and promote individual and community empowerment. The annual **cost** of providing HIV-related services to Latino populations is estimated at **$49,788,000**.[74]

1. e) Unique Service Delivery Challenges

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

Growing Population of Persons with HIV including Individuals with Multiple Needs: It is important to remember that despite diminishing financial resources, there are today more persons living with HIV in the San Francisco EMA than at any point in the history of the epidemic - an increase of more than 50% over the last 12 years alone. **This crisis requires increased resources, not reduced ones.** The estimated **23,930** persons living with HIV and AIDS as of December 31, 2009 represent **73.7%** of the total 32,476 AIDS cases **ever diagnosed** in the San Francisco EMA, and is **12% more** than the 21,331 people who had died from AIDS in the region through the end of 2009. Because of our unparalleled success in bringing large percentages of persons with HIV into care, supporting the cost of their medications and treatment, and providing support to help them remain stable and compliant, persons with HIV in the region are **living much longer and more productive lives** than would previously have been thought possible, while progressing to AIDS at a progressively slower rate – this in spite of the growing need and complexity of the HIV-infected population. **The reduction in the rate of new annual AIDS cases in the region is a sign of the success of the San Francisco system of care in preventing HIV-infected people from progressing to AIDS.**

However, local HIV-infected populations are not only growing – they are becoming **much more challenging to serve**, presenting a greater range of pre-existing physical, psychosocial, and financial issues than at any point in the past. The following selection of characteristics of the local epidemic alone are staggering: **Two-thirds** of persons living with HIV and AIDS and **one hundred percent** of persons in the Ryan White system are living at or below 300% of federal poverty level;[75] **One in four** persons with HIV have no form of health insurance;[76] **One in ten** persons newly diagnosed with AIDS in the EMA is homeless;[77] As many as **half** of MSM living with HIV in the EMA suffer from depression;[78] **Thirty percent** of local PLWHA are active substance users;[79] **One in seven** persons with HIV in the EMA speaks a primary language other than English;[80] **As many as one-third** of gay-identified men in the San Francisco EMA may be

HIV-infected;[81] **Thirty-five percent** or more of transgender persons are believed to be HIV-infected, including **over half** of all African American male-to-female transgender persons.[82]

Ironically, it is precisely because the San Francisco system of care has been so successful at bringing people into care and preserving their health that the system faces the unprecedented pressures with which it is currently struggling. Success in increasing lifespan compels the system to provide supportive services, including financing expensive medications for a growing population over a greatly increased length of time. Additionally, **more and more individuals move to the San Francisco EMA** to access its high level of services, creating a growing burden on the system from outside the region without adding to the region's reported HIV/AIDS caseload because these individuals were first diagnosed with HIV elsewhere. All PLWHA participating in the 2008 San Francisco HIV Needs Assessment, for example, were asked where they had received their original HIV diagnosis and **nearly 40% reported that they had initially tested positive for HIV outside of the San Francisco EMA**, and had moved to the region to receive care.[83]

Escalating Co-Morbidities: Section 1.b above describes several co-morbidities critical to the complexity of providing care in the San Francisco EMA. However, these are by no means the only key issues contributing to the growing complexity of the HIV epidemic in San Francisco. The problem of **substance use**, for example, plays a central role in the dynamics of the HIV epidemic, creating challenges for providers while presenting a critical barrier to care for HIV-infected consumers. The EMA is in the throes of a major substance abuse epidemic which is fueling the spread not only of HIV but of co-morbidities such as sexually transmitted infections, hepatitis C, mental illness, and homelessness - conditions that complicate the care system's ability to bring and retain PLWHA in care. According to the California Office of Statewide Health Planning and Development, an average of **8.5** hospitalizations per 10,000 occurred in San Francisco from 2006 to 2008, well above the average statewide rate of **6.6** per 10,000.[84] Over the same time, the rate for drug-induced deaths in San Francisco stood at **24.8** per 100,000, more than double the statewide rate of **10.8** per 100,000.[85] Drugs and drug-related poisonings are also the **leading** cause of injury deaths among San Franciscans, **with nearly three San Franciscans dying each week of a drug-related overdose or poisoning.**[86] In terms of HIV, the most alarming current threat involves the local epidemic of **methamphetamine (speed).** Health experts currently estimate that up to **40%** of gay men in San Francisco have tried methamphetamine,[87] and recreational crystal use has been linked to **30%** of San Francisco's new HIV infections in recent years.[88]

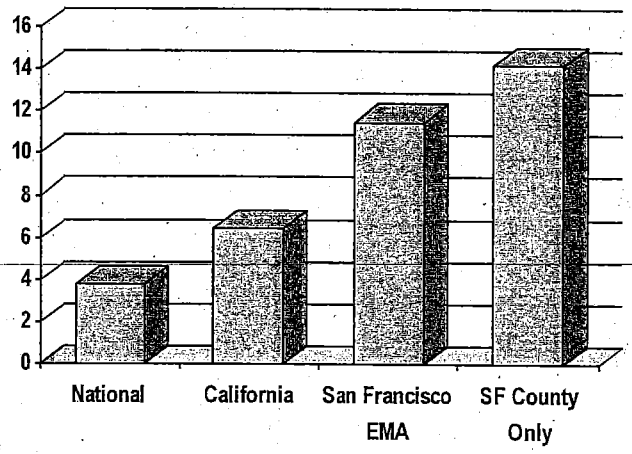
The costs associated with the substance addiction epidemic in the San Francisco EMA add significantly to the local burden of HIV care. According to the National Office of Drug Control Policy, the nationwide societal costs of drug abuse in the year 1998 alone totaled **$143.4 billion.**[89] The National Institute on Drug Abuse reports that it costs an average of **$3,600 per month** to leave a drug abuser untreated in the community; while incarceration related to substance use costs approximately **$3,300 per month.**[90] Such costs can be significantly offset by drug treatment services, which are estimated to save between **$4** and **$7** for every dollar spent on treatment. An average course of methadone maintenance therapy, for example, costs about **$290** per month, while a range of methamphetamine treatment programs currently operating in San Francisco cost between **$2,068** and **4,458** for a single course of treatment.[91]

Injection drug use in the San Francisco EMA is closely related to the growing local epidemic of **hepatitis C**. Because it is a blood-borne infection, hepatitis C is closely tied to injection drug use, and is a frequent co-factor for persons living with HIV/AIDS, complicating

care and frequently leading to severe long-term health consequences. **The San Francisco Department of Public Health estimates that as many as 90% of all chronic injection drug users over the age of 30 may already be infected with hepatitis C.** Co-infection with hepatitis C can make persons living with HIV unable to take or tolerate new treatments, and is the leading cause of death from chronic liver disease in America.[92] Existing hepatitis C treatments are also costly, and are effective for only about **50%** of people who take them. A single 48-week treatment course of injected interferon and oral ribavarin costs more than **$20,000.**[93] One study estimated a total of **$10.7 billion** in direct medical care costs related to HCV in the US .for the years 2010 to 2019, along with a combined loss of **1.83 million years of life** in those younger than 65 at a societal cost of **$54.2 billion.**[94] **The HIV care system is rapidly becoming the default medical provider for persons with hepatitis C - a trend which, as persons with HCV age, will place enormous cost burdens on the HIV care system.**

Tuberculosis (TB) is another critical health factor linked to HIV, particularly in terms of its effects on recent immigrants and the homeless. The magnitude of the local tuberculosis crisis is comparable to that of syphilis and gonorrhea, with a total of **196** new cases of TB diagnosed in the San Francisco Metropolitan Area in 2009, representing an EMA-wide incidence of **11.5** cases per 100,000.[95] In San Francisco, the incidence is even higher, at **14.2** cases per 100,000. **San Francisco's TB incidence rate is more than double than the statewide rate of 6.4 cases per 100,000, and nearly 300% higher than the national rate of 3.8 cases per 100,000** (see Figure 8).[96] Rates of new TB infection in San Francisco are highest among Asian populations (**64.4%** of new TV cases in 2009), reflecting the disease's heavy impact on recent immigrant populations. Treatment for cases **of multidrug-resistant tuberculosis** are particularly expensive, with one nationwide study indicating that the cost of treating multidrug-resistant TB - including indirect costs to families - averaged **$89,594** per person for those who survived, and as much as **$717,555** for patients who died.[97]

Figure 8. New 2009 Tuberculosis Cases Per 100,000 Population



The high prevalence of **mental illness** and **mental health issues** in the San Francisco EMA further complicates the task of delivering effective services and retaining persons with HIV in care. The San Francisco Department of Public Health, Behavioral Health Section reported in its most recent report that **12,000** seriously emotionally disturbed children and youth and **32,000** seriously mentally ill adults live in San Francisco, and that up to **37%** of San Francisco's homeless population suffers from some form of mental illness.[98] 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.[99] 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%.**[100] 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.[101]

Concentration of HIV/AIDS Cases: Imagine standing in a crowded bus or train during rush hour in a major U.S. city. On that train in San Francisco, the odds are extremely high that at least **two** people will have HIV. As noted above, **1 in every 36** residents of the city is currently living with HIV disease, including as many as **one out of every three** gay-identified men. In most major U.S. cities, the burden of the HIV epidemic is spread across a relatively large region, with more facilities available to provide care for broadly dispersed groups of patients. The City of San Francisco, however, is **less than seven miles long by seven miles wide,** which means that this population must be cared for within a very limited space that has fewer health and social service facilities available to meet client needs.

In San Francisco, the concentrated demand results in HIV services being compressed within individual provider agencies that are struggling to cope with HIV caseloads many times larger than they were originally established to serve. Lag times between initial inquiries and appointments are becoming progressively longer, and clients are experiencing greater delays in obtaining key services. The increasing complexity of HIV-infected populations also means that local agencies must cobble together combinations of full-time and part-time staff, resulting in higher levels of employee turnover and attrition.

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

The San Francisco EMA has been hard-hit by a series of reductions in Part A formula and supplemental funds that have stripped nearly **50%** of the EMA's combined Ryan White funding over the past 10 years. The hold harmless provision of the Ryan White HIV/AIDS Treatment Extension Act of 2009 between 2010 and 2014 does not include a supplemental funding restoration to the San Francisco EMA, which translates to a potential 5% cut to formula portion of the RWPA award. The lack of security for level formula funding for the EMA creates a sense of instability in the system and obstacles to planning responses to emerging needs. Additionally, steady reductions in formula and supplemental funding over the past half decade have led to the broadening of waiting lists at a number of key agencies and regional Centers of Excellence – including the Mission Center of Excellence and the Tenderloin Health Services Center of Excellence - and to a lack of immediate access to care for newly infected individuals. In July 2008, a highly popular HIV dental clinic located at University of the Pacific in San Francisco was forced to discontinue clinics due to cuts in State Denti-Cal reimbursements, depriving hundreds of low-income HIV-infected men and women of quality dental care. Prior Part A funding reductions had forced the agency Continuum to close its unique adult day care program located in the Tenderloin area of San Francisco - the only program of its kind in the state - and had caused the elimination of a medical van transportation service provided by Shanti which has since created significant barriers in terms of accessing care. In Marin County, reductions forced the elimination of the region's Volunteer Services program which provided practical, emotional, and transportation support to clients, including programs for driving clients to medical appointments and training disabled persons with HIV to learn marketable computer skills. Marin County funding cuts also made it unfeasible to contract with the Marin Community Food Bank to provide home-delivered food to homebound clients. Instead, the County's food service will

now consist of food gift cards made available to only the most severe need clients who must now shop for and prepare their own meals. At the same time, on-going efforts to identify and bring into care new persons with HIV who are unaware of their status will also place additional burdens on a system already stretched to the breaking point. **To preserve a basic level of care for persons with HIV in the hard-hit Bay Area region, the SF EMA seeks a significant measure of Part A formula and supplemental funding restoration through the FY 2011 allocation process in order to avoid significant reductions in the quality and length of life of persons with HIV in the region.**

1.g) UNMET NEED

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

1.g.2) Unmet Needs Trends

The table below lists percentage of unmet need in San Francisco for the years 2007–2009, based on calculations made for a July 1 – June 30th cycle for each year and reported in each year's Ryan White Part A application. **The table demonstrates a significant decrease in the percentage of persons considered to be out of care in the EMA, from 22% in 2007 and 23% in 2008 to 18% in 2009.** The decrease in unmet need is believed to be based on the EMA's continuing success in aggressively identifying and linking to care persons who had either dropped out of care or who had previously been unaware of their HIV status.

Reported Percentages of Unmet Need in San Francisco EMA – 2007 - 2009		
2007-2008	2008-2009	2009-2010
22%	23%	18%

1.g.3) Incorporation of Unmet Needs Trends in Local Planning

As described in greater detail in Section 5.b below, the San Francisco HIV Health Services Planning Council annually reviews a summary estimate of unmet need among PLWA and PLWHA in the San Francisco EMA utilizing HRSA's unmet needs framework, including a detailed breakdown of unmet need by population, and an analysis of EMA neighborhoods in which unmet need is most prevalent. Both the 2008 Comprehensive Needs Assessment and the 2010 Qualitative Update also included a heavy emphasis on specifically assessing unmet HIV service needs, yielded critical information that was used by the Council in its prioritization and allocation process. This included information ranking Part A service categories in terms of those most utilized and most needed by PLWHA, along with recommendations for addressing gaps in service delivery to ensure a more comprehensive system of care. The Planning Council utilizes unmet needs data both to target the EMA's outreach and care linkage activities to persons who have fallen out of care, and to anticipate future trends regarding the nature and composition of HIV care populations who may enter the system in the future.

1. g.4) Estimation and Utilization of Unmet Needs Data

This year's unmet need analysis targeted persons living with AIDS (PLWA) and persons living with HIV/non-AIDS (PLWH) in the San Francisco EMA during the 12-month period from **July 1, 2008 through June 30, 2009.** The analysis included overall unmet need analyses as well as subpopulation analyses for PLWA and PLWH. These estimates were produced by the SF Department of Public Health HIV/AIDS Statistics and Epidemiology Section, and utilized the

unmet need framework methodology developed by the University of California, San Francisco Institute of Health Policy Studies – the framework that is specifically recommended by HRSA. The timeframe chosen for the unmet need analysis was based on the most recent 12-month interval for which care data were complete from all available data sources. In accordance with HRSA guidelines, PLWA and PLWH were considered to have a **met** need for HIV-related primary medical care if any data source indicated that they received antiretroviral therapy or had at least one CD4 or viral load test during the 12-month period from July 1, 2008 through June 30, 2009. Separate unmet need estimates for PLWA and PLWH could be generated as all population and care data sources contained information on AIDS/HIV status.

An estimated **20,445** PLWA and **16,791** PLWH who were aware of their HIV status resided in the S.F. EMA from July, 2008 through June, 2009 (see **Attachment 7**). A total of **1,114** PLWA and **2,540** PLWH did not receive primary medical care during that time period. Unmet need was thus **18%** overall, and - as would be expected - was higher among PLWH (**27%**) than among PLWA (**10%**). **The 18% overall unmet need estimate is significantly lower than last year's estimate of 23%.**

Determination of Demographics of Out of Care Populations: Improved data collection and reporting systems in the San Francisco EMA have given the SF EMA the important ability to compare specific unmet need among PLWHA. For the period July 1, 2008 through June 30, 2009 we estimated these populations across four critical categories: HIV/AIDS status, gender, race/ethnicity, and age group – results that are reported in Figure 9 below.

Assessment of Service Gaps, Needs, and Barriers to Care: Continually improving and refining the process of determining unmet need - and doing so in a manner that allows the Planning Council to allocate funds to bring the greatest number of out-of-care individuals into care - remains a high priority for the San Francisco EMA. One of the most important approaches the EMA uses to accurately quantify the full number of persons living with HIV in the region involves the use of **consensus meetings** in which local and regional researchers, epidemiologists, and community providers participate in a process to estimate the number of persons with HIV living in each of the EMA's counties as a proportion of the total number of persons living with AIDS. The most recent consensus process, conducted in August 2010, resulted in a sound estimate of the PLWH populations of both San Mateo and Marin Counties. Meanwhile, continual improvements in the utilization of the State's HIV and AIDS Reporting System (HARS) by the City and County of San Francisco enabled the utilization of **HARS data only** as a basis for quantifying the total number of non-AIDS PLWH living in the City. This allows for the production of much more accurate and detailed representations of PLWH.

Efforts to Identify People Not in Care and Assist Them in Accessing Primary Care: **The San Francisco HIV Health Services Planning Council utilizes the results of the Unmet Needs Framework and related data to directly aid in planning and decision-making regarding priorities, resource allocations, and the local system of care.** In 2003, for example, the San Francisco EMA conducted an analysis which utilized census tract data from HIV/AIDS case reports to determine unmet need by neighborhood among **11,057** San Francisco residents living with AIDS and HIV. This study found that the proportion of PLWH with unmet need for medical care was higher in lower-income neighborhoods such as **Ingleside, the Tenderloin, Bayview/Hunters Point,** and **Downtown** (median household income $21,347-$46,441). As might be expected, the absolute number of persons with unmet need was highest in neighborhoods where the largest number of PLWA and PLWH reside (i.e., the Castro and the Tenderloin, each with more than **2,000** PLWHA). The city's Centers of Excellence program was

Figure 9.
San Francisco EMA Demographic Analysis of People in and Out of Care
July 1, 2008 through June 30, 2009: ALL Persons Living with HIV or AIDS (PLWHA)*

Characteristic	#1: PLWHA Population	#2: Number with Met Need	#3: Number with Unmet Need	#4: % of Unmet Need Population**	#5: % of Category with Unmet Need**	#6: % of Total PLWHA Population**
All PLWHA	20,445	16,763	3,682	100%	18%	100%
HIV/AIDS Status						
PLWA	11,077	9,962	1,115	30%	10%	54%
PLWH / no AIDS	9,368	6,801	2,567	70%	27%	46%
Gender						
Male	18,792	15,613	3,179	86%	17%	92%
Female	1,653	1,150	503	14%	30%	8%
Race/Ethnicity:						
White	12,646	10,378	2,268	62%	18%	62%
African American	3,050	2,485	565	15%	19%	15%
Latino	3,305	2,771	534	15%	16%	16%
Asian/PI	1,045	873	172	5%	16%	5%
Other	399	256	143	3%	36%	2%
Age in Years:						
0-19	109	79	30	1%	28%	1%
20-29	880	670	210	6%	24%	4%
30-39	3,209	2,490	719	20%	22%	16%
40-49	7,904	6,436	1,468	40%	19%	39%
50-59	6,028	5,108	920	25%	15%	29%
60 or older	2,315	1,980	335	8%	14%	11%

* Excludes PLWH (non-AIDS) not aware of their HIV status.
** Column calculations: Column #4 = Column #3 / total with unmet need (n=3,682); Column #5 = Column #3 / Column #1; Column #6 = Column #1 / total number PLWHA (n=20,445)