FY 2014 PROJECT ABSTRACT

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

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

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

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

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

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

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

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

NEEDS ASSESSMENT

1) DEMONSTRATED NEED

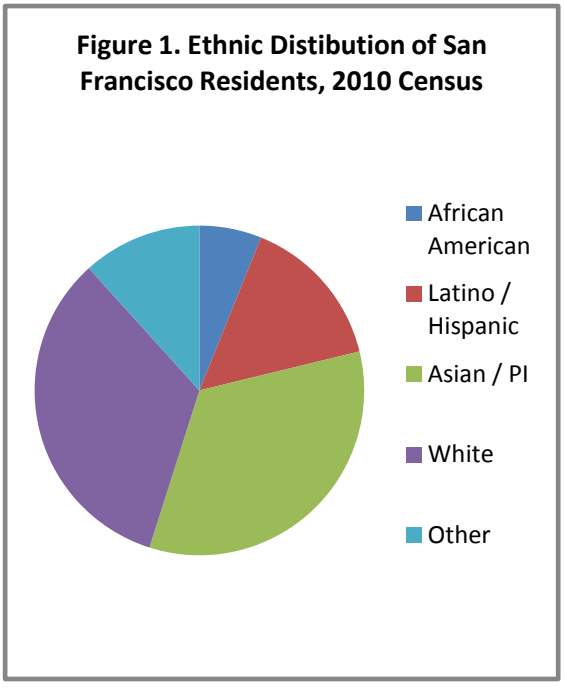
Introduction to the San Francisco EMA

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

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

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

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



1.A) HIV/AIDS Epidemiology

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

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

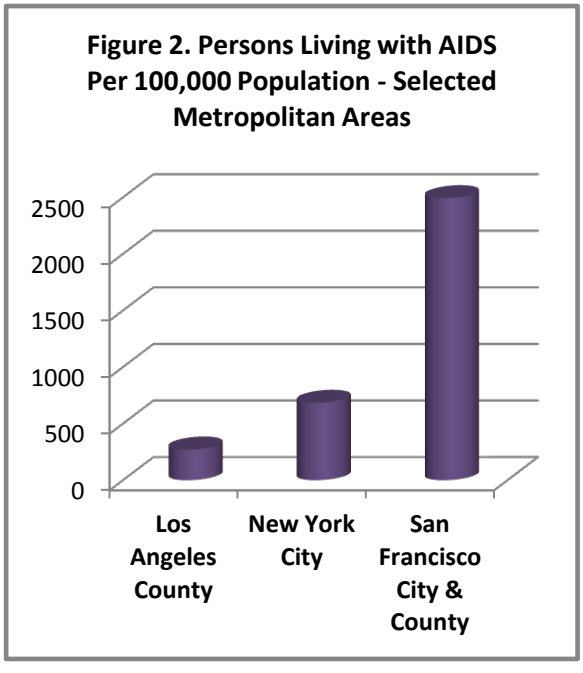
1.A.2) HIV/AIDS Epidemiology Narrative

Description of Current HIV/AIDS Cases:

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

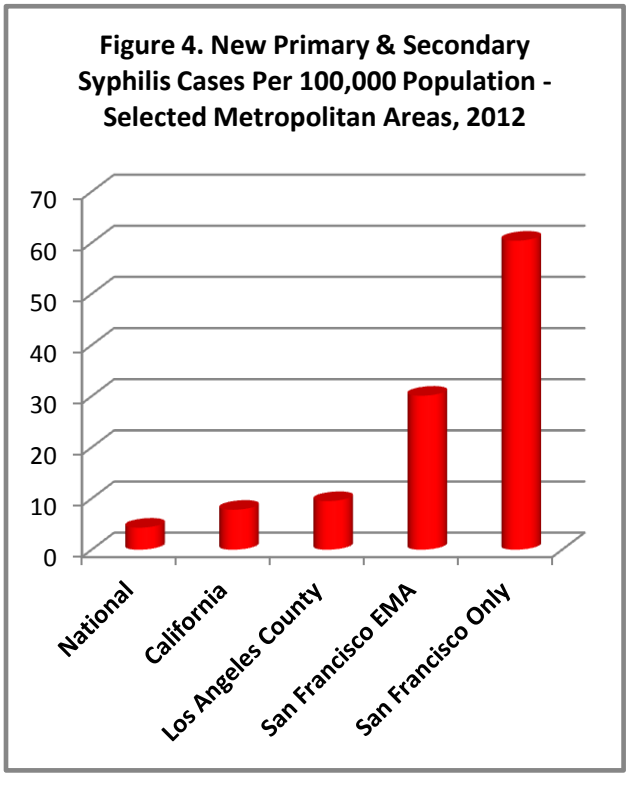
who have low incomes, with fully **95%** of survey respondents reporting that their last health care visit for HIV/AIDS had been within the past six months. While the majority of needs assessment respondents stated that they were able to access needed care services, challenges and barriers to health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

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

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

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

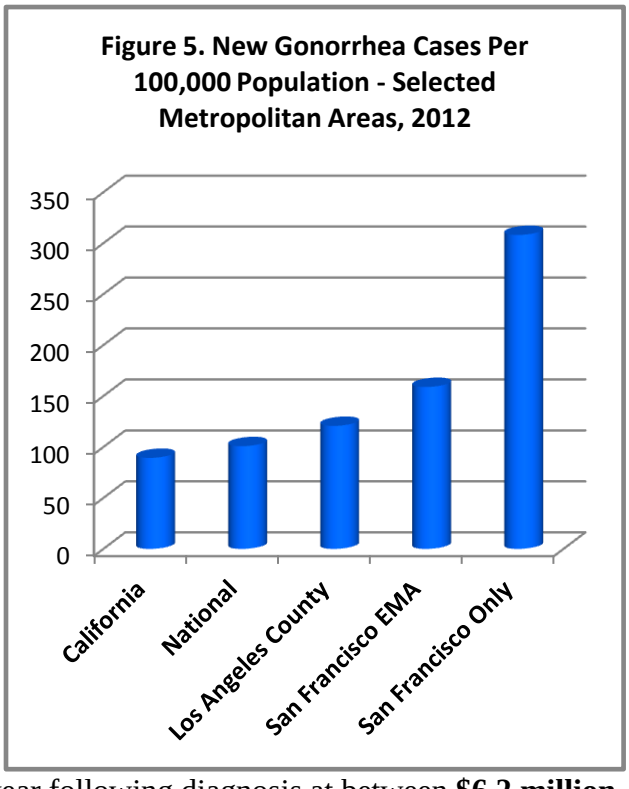
Sexually Transmitted Infection (STI) Rates: The growing crisis of **sexually transmitted infections** is of significant concern for the future of the HIV epidemic in our region**.** In terms of **syphilis,** for example, the San Francisco EMA continues to confront a **major epidemic** that has been escalating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



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

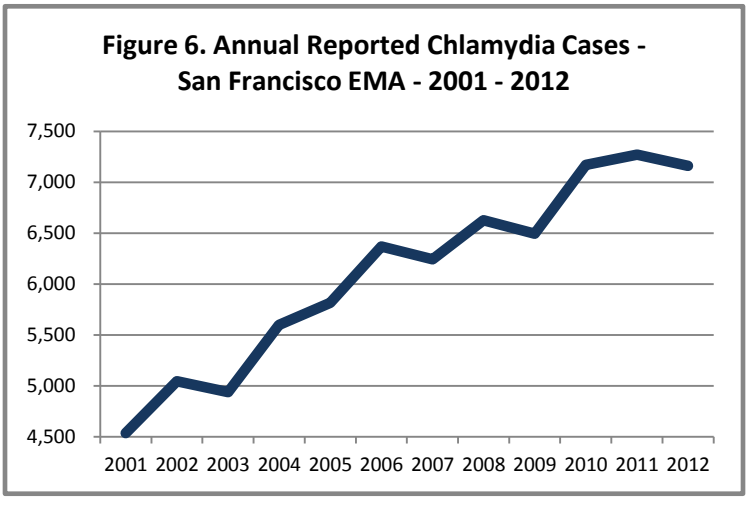
The San Francisco EMA's **Chlamydia**

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



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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

1.B.3) Impact of Formerly Incarcerated Individuals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.D) Assessment of Populations with Emerging Needs

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

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

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

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

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

Demographic Categories	Number	Percent
Gender		
Male	9.235	92.5%
Female	613	6.1%
Transgender	137	1.4%
Ethnicity		
White	6,804	68.1%
African American	1,463	14.7%
Latino	1,219	12.2%
Asian / Pacific Islander	352	3.5%
Other / Unknown	147	1.5%
Transmission Categories		
MSM	7,258	72.7%
Injection Drug Users	868	8.7%
MSM Injection Drug Users	1,2620	12.6%
Non-IDU Heterosexuals	346	3.5%
Other / Unidentified	251	2.5%
Time Since 1st HIV Diagnosis		
0 - 2 Years	246	2.5%
3 - 5 Years	437	4.4%
6 - 10 Years	1,169	11.7%
11 - 15 Years	2,012	20.2%
16 - 20 Years	3,113	31.2%
More Than 20 Years	3,008	30.1%
TOTAL	**9,985**	**100.0%**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.E) Unique Service Delivery Challenges

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

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

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

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

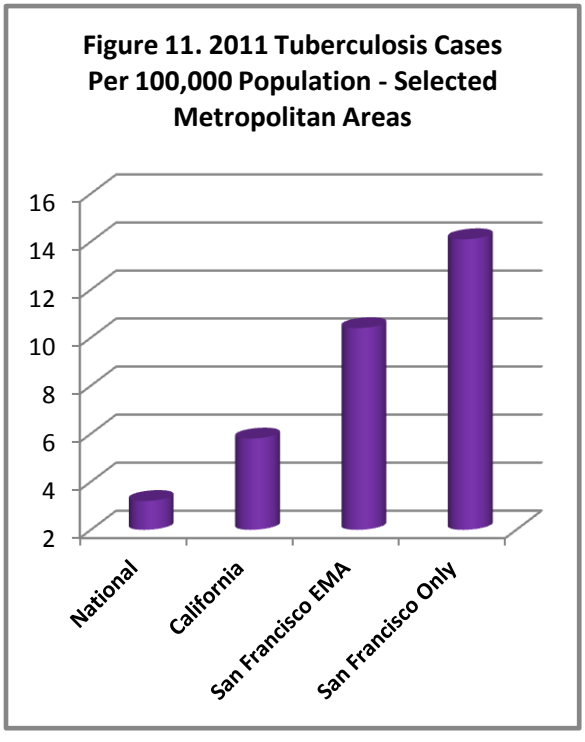
unprecedented pressures with which it is currently struggling. Success in increasing lifespan compels the system to provide supportive services, including financing medications for a growing population over an increased length of time. Additionally, more and more individuals move to the San Francisco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

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

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

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

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



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

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

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

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

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

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

1.G) UNMET NEED

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

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

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

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

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

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

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

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

1.G.3) Unmet Need Trends

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

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

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

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

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