SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH HIV HEALTH SERVICES
ENDING THE HIV EPIDEMIC: A PLAN FOR AMERICA
RYAN WHITE HIV/AIDS PROGRAM PARTS A & B COOPERATIVE AGREEMENTS

FISCAL YEAR 2026 NONCOMPETING CONTINUATION PROGRESS REPORT

1. Recipient Information

Organization:	San Francisco Department of Public Health (SFDPH)
Program Title:	HIV Health Services (HHS)
Program Director:	Bill Blum, MSW
Cooperative Agreement Number:	UT8HA33951
Name of person preparing this report:	Andrew "Andy" Scheer, LCSW
Title:	SFDPH HHS EHE Coordinator / Health Program Coordinator III
Phone Number:	628-206-7675
E-mail:	andy.scheer@sfdph.org

2. Progress on Goals and Objectives

There have been no significant changes to the San Francisco Department of Public Health (SFDPH) HIV Health Services (HHS) section's EHE project activities, as outlined in the current work plan, since the most recent biannual progress report was submitted on September 30, 2025. SFDPH HHS continues to implement, support, monitor, and report on the existing **16 EHE core services interventions and 2 EHE linkage-to-care interventions** currently being implemented by **9** separate agencies under **7** HRSA HAB service categories, all of which have the goal of reaching and serving the most complex, high-need and low-income people living with HIV in the San Francisco EMA. The overarching goal of these programs is to continually increase the number of people with HIV in our region who have undetectable viral load levels by progressively increasing engagement and retention in low-barrier, intensive HIV care and support services for highly marginalized and multiply diagnosed populations. Each EHE-funded intervention has been strategically selected to address the special needs and service gaps affecting people with HIV who are disengaged or loosely connected to care and support services, including those experiencing homelessness, recently released from incarceration, and dealing with dysregulated substance use and mental health disorders. According to the **EHE**

Initiatives Viral Suppression Dashboard specifically created by HHS to monitor and report on progress toward viral suppression among EHE-funded providers, **836** overall unduplicated clients (UDC) were provided EHE services between March 1 and October 31, 2025, with **250** UDC served under the 2 EHE linkage-to-care interventions. A remarkable **78%** viral suppression rate was achieved among the 645 unduplicated clients served by the 18 core EHE interventions during this time period.

In addition to the ongoing work of our subcontracted providers – all of whom continually collaborate with and report to HHS on program activities, issues, and impacts – the SFDPH Business Office of Contract Compliance (BOCC) is currently concluding its **annual program monitoring site visits,** designed to provide detailed insights on the work and activities of EHE providers while monitoring program compliance and identifying technical assistance needs. 2025 visits completed at the time of this submission include:

- 9/16/25 San Francisco Community Health Center
- 9/18/25 Shanti
- 10/2/25 SFDPH Health at Home
- 10/14/25 UCSF Alliance Health Project
- 10/22/25 SFDPH Whole Person Integrated Care Maria X Martinez Health Resource Center
- 10/24/25 SFDPH SF City Clinic LINCS Navigation
- 10/30/25 UCSF Ward 86 POP-UP
- 11/6/25 SFDPH Castro-Mission Health Center

Additional monitoring site visits of other EHE sites will be completed by the end of the 2025 calendar year, with results included in monthly EHE reports to HRSA HAB EHE Project Officer.

On Tuesday, May 20, 2025, HHS - through a braided funding collaboration with the SFDPH Population Health Division's (PHD) Community Health Equity and Promotion (CHEP) section overseeing CDC-funded HIV prevention activities in SF - presented **Onboard SF: A Frontline Worker's Summit,** with **80** people in attendance. This first-ever summit was designed for workers who are relatively new to the field of HIV care and prevention and drug user health and was designed to help them build a community of colleagues; gain a baseline understanding of the systems in which they are working; learn about the core tools available to them; and accelerate their impact as new workers in the field. A variety of training methodologies were used including icebreakers, didactic presentations, interactive activities, asynchronous learning opportunities, breakouts, and panel presentations.

B. EHE Planned Activities for Fiscal Year 2026

a. New EHE Activities During the Next Budget Year: Because of the ongoing success of HIV Health Services' EHE program matrix and the uncertain status of future EHE funding levels as well as RWPA, B, and C funding in our region, our Section plans to continue our current configuration of EHE services for the upcoming fiscal year. Detailed tracking and monitoring will continue to take place involving all EHE-funded agencies and programs, with monthly monitoring updates taking place with our

assigned Project Officer, including both fiscal and programmatic updates. HHS will also continue to build skills and capacity among its funded providers, while facilitating opportunities for mutual planning, information exchange, and systematic implementation of best practices identified through innovative program design.

One of the most important initiatives to be expanded during the upcoming fiscal year involves our leadership and extensive participation in the **SFDPH HIV Injectables Work Group (HIWG).** No EHE funds are allocated to this group's work rather, the focus is on coordination of existing resources to maximize system-wide impact. The Work Group was formed in mid-2025 with the express goal of expanding awareness and building capacity to implement long-acting injectable antiretroviral treatment (LAI ART; injectable ART) among public HIV clinical providers in the San Francisco EMA. Injectable ART is of critical importance in facilitating HIV treatment adherence among EHE clients who face a broad range of challenges in adhering to daily oral treatment regimens, and whose rates of viral suppression could increase significantly through injectables use. The Work Group is comprised of key planners and providers of both HIV prevention and care services in our region, and its activities are initially focused on:

a) Building capacity around long-acting injectables for HIV treatment and prevention at SFDPH clinics
b) Preparing SFDPH clinics for an anticipated influx of patients interested in injectables, while
c) Developing initiatives to promote injectables among both providers and clients.

During the upcoming EHE project year, the HIV Injectables Work Group will continue to expand and refine an **HIWG Maximizing HIV Injectables** handbook it has already drafted. The handbook will outline ways in which SFDPH clinics can start an HIV injectables program or expand their current use of injectables through the adaptation of standard clinic protocols and workflows, dissemination of client and staff education materials, incorporation of Epic electronic medical records system clinical panel management tools into daily practice, and utilization of clinical quality management tools developed to monitor and improve service delivery. The handbook will also highlight the availability of new technical assistance services through **two new TA teams** that we have already organized under the HIWG umbrella – one focused on treatment injectables and the other on prevention injectables. Both teams will utilize a status-neutral, cross-fertilized approach, sharing information on both prevention and care injectables in all presentations, while emphasizing the importance whole person care in delivering injectables education and services. The Work Group will also collaborate with San Francisco's Getting to Zero consortium on further development of the existing referral list for injectables providers and resources in San Francisco and will later expand its outreach, education, and support services to include community clinics and FQHCs.

Additionally, in coordination with the SFDPH HIV prevention section, CHEP, the HHS EHE Coordinator participates in a **bi-monthly program implementation meeting with UCSF Ward 86**, the clinic implementing EHE Initiatives focused on injectable ART and drop-in primary care, psychiatry, and case management services for people experiencing homelessness. The EHE Coordinator and the HIV prevention section also hold a monthly EHE Initiative meeting with staff implementing EHE work at **SFDPH Whole Person Integrated Care's Maria X. Martinez**

Health Resource Center and Street Medicine programs.

b. Current EHE Activities to be Continued or Expanded: As noted above, the San Francisco Ending the HIV Epidemic (EHE) initiative currently funds a total of **18** targeted, strategic initiatives through **9** separate agencies under **7** HRSA HAB service categories. All of these initiatives will continue to focus on low-barrier, rapid entry and re-entry into HIV care, along with intensive support services for people with persistent difficulties in achieving and maintaining HIV viral suppression. Our EHE initiatives will continue to prioritize clients with HIV who are disengaged from or loosely engaged in care and treatment, as well as those whose substance use, mental health, and housing instability issues create severe barriers to achieving and maintaining viral suppression. Detailed tracking and monitoring using data extracted from the State of California Office of AIDS data system HIV Care Connect and local Epic electronic medical record system will continue to take place involving all funded agencies and programs so that HHS can evaluate outcomes. HHS will continue to build skills and capacity among its funded providers through educational, information-sharing, and mutual planning opportunities.

c. Lessons Learned from Previous Year: All EHE funded programs are specifically designed to identify and address barriers to linkage, engagement, and retention in HIV care. These approaches are grounded in an understanding of the severe needs faced by the targeted sub-populations, who have almost universally experienced trauma, discrimination, and marginalization, and the great majority of whom have had prior traumatic experiences with the traditional medical and social service systems. As described above, EHE programs present innovative and intensive models for building trust and communication with client populations; maintaining frequent contact with patients, including through **weekly** appointments in the case of both HHOME and POP-UP; and utilizing an approach which does not judge or pressure clients to make changes or modify behaviors until they are comfortable and ready to do so. The programs also use as many additional strategies as possible to retain clients in care and on HIV medications, such as the use of a broad range of patient incentives; the distribution of low-cost, disposable cell phones to maintain contact with homeless clients; and approaches in which staff **come to the client** where needed, instead of exclusively expecting clients to come to them. HIV Health Services continually collects and reports both quantitative and qualitative data regarding these programs and uses this data to work with agencies to address any deficiencies in regard to project objectives or to address identified disparities in the characteristics of project populations. These approaches will continue to be refined and expanded over the upcoming EHE Fiscal Year.

C. Technical Assistance

a. Technical Assistance Received in Current Project Period: In 2025, HHS embarked on a new TA collaborative with Georgetown University to develop a comprehensive data collection and evaluation plan for the new HIV Injectables Working Group using, in part, Power BI - a business analytics platform developed by Microsoft that helps users connect to and visualize data from various sources to create reports and dashboards. At the time of this writing, HHS has met with Georgetown TA providers **6 times** to develop the HIWG evaluation plan. HHS is currently

developing a logic model and conducting initial stakeholder mapping as part of the next stage of evaluation planning.

Additionally, HHS participated in the EHE Intensive Technical Assistance Workshop presented by HRSA on June 24 and 25 in San Diego, as well as the HRSA HAB Administrative Reverse Site Visit conducted August 6-8 of this year.

b. Anticipated Technical Assistance Needs in FY 2026: This new collaboration with Georgetown University is expected to continue throughout the current 5-year EHE cycle as a way to both monitor the impact of the Injectables Work Group and to increase the overall reliability, usability, and scope of existing reporting around viral suppression attainment by EHE clients – information that will be continually shared with EHE subcontractors.

D. Personnel

At the present time, the program has no staffing needs or vacancies that impact our ability to implement EHE activities.

E. Budget

See budget documents on the following pages.

Contractual						
List of Contracts	**Deliverables by HRSA HAB Service Category** (service description)	**Program Descriptions**	**FY2025 Allocated Funds**	**FY2025 Obligated Funds**	**FY2025 Expended as of 10/31/25**	**Anticipated Expenditure by end of 2025 Fiscal Year**
San Francisco Community Health Center HHOME and GTZ ICM	**Medical Case Management** (Intensive Master's-level Social Work, paraprofessional Medical Case Management, and Licensed Vocational Nurse Services)	Mobile and agency-based programs focused on HIV+ homeless and unstably-housed individuals, to connect/re-connect them to medical care and support services in order to reach and sustain HIV viral suppression and promote community stability. Services delivered by a Master's Level Social Workers, paraprofessionals, and Licensed Vocational Nurses. **Program Costs** arrived at by staff FTE and salary for staff to successfully provide services to a census of homeless clients with complex medical and social service needs, an acceptable portion of program operating and indirect costs are also included. **EHE Impact**: 100 clients served; 80% of HHOME and EHE ICM clients reach and sustain HIV viral suppression	**$ 790,501**	**$ 790,501**	**$ 495,975**	**$ 294,526**
UCSF Ward 86 POP-UP at Ward 81	**Outpatient/Ambulatory Health Services** (MD, NP, RN) **Mental Health Services** (Psychiatrist) **Medical Case Management** (Master's-level Social Work)	Open access primary care clinic located at SF General Hospital, Ward 81 providing multidisciplinary, team-based medical care by MDs, NPs, and RNs, psychiatry through consultation and direct service, and medical case management services by Licensed Clinical Social Workers for homeless and other individuals who benefit from a drop-in primary care model with high utilization of Injectable Antiretroviral Treatment to achieve and sustain HIV viral suppression and intensive wrap-around services to aid transition into a traditional primary care environment. **Program Costs** arrived at by staff FTE and salary for staff to successfully provide services to a census of homeless and marginally-housed clients with complex medical and behavioral healthcare needs. An acceptable portion of program operating and indirect costs are also included. **EHE Impact:** 165 clients served; 80% of POP-UP EHE clients reach and sustain HIV viral load suppression.	**$ 527,218**	**$ 527,218**	**$ -**	**$ 527,218**
UCSF Alliance Health Project EHE ICM	**Medical Case Management** (Master's and Bachelor's-level Clinical Case Management)	Intensive case management (ICM) services for clients of the SF General Hospital Ward 81 POPUP clinic and AHP's behavioral healthcare center who require intensive, mobile behavioral health services to achieve and sustain HIV viral suppression and community stability. **Program Costs** arrived at by staff FTE and salary for staff to successfully provide services to a census of homeless and unstably-housed clients with complex medical and behavioral healthcare needs. An acceptable portion of program operating and indirect costs are also included. **EHE Impact:** 60 ICM clients served; 80% of AHP ICM clients will reach and sustain HIV viral load suppression	**$ 238,199**	**$ 238,199**	**$ -**	**$ 238,199**
SFDPH Whole Person Integrated Care (WPIC) HIV Transitional Primary Care and Navigation	**Outpatient/Ambulatory Health Services** (MD) **Medical Case Management** (Intensive Care Navigation) **Emergency Financial Assistance** (Emergency Antiretroviral Treatment)	Transitional HIV Primary Care clinic embedded in an urgent care clinic for people experiencing homelessness, located in the South of Market neighborhood of San Francisco, providing extremely low barrier entry into care, immediate access to ART when faced with insurance barriers to medication access, and intensive care navigation into primary care medical clinics after clients are stabilized. **Program Costs** arrived at by staff salaries and FTE required to successfully provide medical care, injectable ART, and intensive care navigation to a caseload of homeless and active substance-using clients as well as by the cost of medication purchased under 340b pricing. An acceptable portion of program operating and indirect costs are also included. **EHE Impact:** 75 transitional primary care and navigation clients served; 80% of WPIC MXM clients will achieve and maintain HIV viral load suppression.	**$ 189,305**	**$ 189,305**	**$ 114,739**	**$ 74,566**
SFDPH Linkage, Integration, Navigation & Comprehensive Services (LINCS) LINCS Navigation	**Non-Medical Case Management** (HIV Care Navigation) **Emergency Financial Assistance** (Emergency Antiretroviral Treatment)	Intensive, field-based linkage to care and systems navigation for HIV+ people disengaged from care who are: in their first six months living with an HIV+ diagnosis and missed one or more appointments, hospitalized with a detectable HIV viral load, are viremic and have not had a primary care appointment in the previous four months, have a CD4 less than 200 and history of viral rebound after initial HIV viral suppression. **Program Costs** arrived at by staff salaries and FTE required to successfully navigate a census of clients disconnected from care due complex systems and psychosocial barriers as well as by the cost of medication purchased under 340b pricing. An acceptable portion of program operating and indirect costs are also included. **EHE Impact:** in conjunction with EHE carryover funds and LINCS case investigation work (EHE Initiative Services category), 100 non-medical case management clients; 80% of patients enrolled in LINCS will have had a primary care visit within 90 days of enrollment; 80% of clients will have achieved HIV viral load suppression	**$ 50,000**	**$ 50,000**	**$ -**	**$ 50,000**

List of Contracts	Deliverables by HRSA HAB Service Category (service description)	Program Descriptions	FY2025 Allocated Funds	FY2025 Obligated Funds	FY2025 Expended as of 10/31/25	Anticipated Expenditure by end of 2025 Fiscal Year
SFDPH Jail Health Services HIV Integrated Services (HIVIS)	**Medical Case Management** (Care Navigation)	Intensive, time-limited HIV care navigation for people currently incarcerated in and recently-released from San Francisco county jails to link the EHE Big Bet population of justice-involved, HIV+ people to care, treatment and wrap-around supportive services that sustain their engagement, viral suppression and community-stability. **Program Costs** arrived at by staff salaries and FTE required to successfully navigate a census of justice-involved clients with complex behavioral healthcare needs from carceral to community setting and support continued engagement in medical care and social services. An acceptable portion of program operating and indirect costs are also included. **EHE Impact:** 50 non-medical case management clients; 80% of HIVIS clients will achieve and maintain HIV viral load suppression.	**$ 49,737**	**$ 49,737**	**$ -**	**$ 49,737**
SFDPH Tom Waddell Urban Health Clinic and Castro-Mission Health Center Injectable ART Panel Management	**Medical Case Management** (Medical Assistant Panel Management)	Panel management by a Medical Assistant (MA) for HIV+ clients on Long-acting Injectable ART (LAI ART; injectable ART) with tasks focused on the coordination of this treatment methodology in two primary care settings including: primary care and injection appointment scheduling, ordering and coordinating delivery of clinic-administered medication, monitoring of lab panels to be conducted, and patient outreach. **Program Costs** arrived at by staff salary and FTE required to successfully support a census of patients on injectable ART; an acceptable portion of program operating and indirect costs are also included. **Work Plan Goals:** 50 medical case management clients; 80% of Injectable ART Panel Management clients will achieve and maintain HIV viral load suppression.	**$ 97,058**	**$ 97,058**	**$ 97,058**	**$ -**
Shanti EHE Housing Navigation	**Non-medical Case Management** (Housing Navigation)	Community- and agency- based housing navigation for People with HIV who are progressing through San Francisco's homeless continuum of care and need intensive housing navigation support successfully transition from homelessness to permanent housing. **Program Costs** arrived at by staff salaries and FTE required to successfully navigate a census of HIV+ homeless clients into permanent housing. An acceptable portion of program operating and indirect costs are also included. **Work Plan Goals:** 30 EHE Housing Navigation clients; 80% of HIVIS clients will achieve and maintain HIV viral load suppression.	**$ 162,676**	**$ 162,676**	**$ 68,912**	**$ 93,764**
SFDPH Health at Home Injectable ART Administration	**Home Healthcare** (LAI ART Administration)	Registered Nurse, Medical Social Work and Home Health Aide services to provide injectable ART administration outside of the clinical setting among clients whose physical and behavioral health conditions impair their ability to engage in a four-walls clinic for adherence to this HIV treatment method. **Program Costs** arrived at by staff salaries and FTE required to successfully navigate a census of HIV+ homeless clients into permanent housing. An acceptable portion of program operating and indirect costs are also included. **Work Plan Goals:** 15 injectable ART clients; 90% of HIVIS clients will achieve and maintain HIV viral load suppression.	**$ 125,000**	**$ 125,000**	**$ -**	**$ 125,000**
UCSF Ward 86 POP-UP at Ward 81	**EHE Initiative Services** (Pharmacy Technician)	Staff to coordinate procurement, receipt, storage, and distribution of injectable antiretroviral treatment (ART) and other medications; facilitate ordering, payment, and delivery of medications with pharmacies; support care engagement, patient education and medication injection appointment adherence through direct and indirect patient interaction **Program costs:** arrived at by staff FTE + salary required to carry out the aforementioned essential functions not otherwise funded under a standard Ryan White service category **EHE Impact:** 50 unduplicated clients and 600 units of service to achieve 85% HIV viral suppression rate among clients on injectable ART	**$64,994**	**$64,994**	**$ -**	**$ 64,994**
SFDPH Linkage, Integration, Navigation & Comprehensive Services (LINCS) LINCS Navigation	**EHE Initiative Services** (Case Investigation Services)	Data-to-care and molecular surveillance case investigation of HIV+ clients identified as out-of-care by SFDPH HIV Surveillance section; investigation of client contact information, continued residency in San Francisco, care engagement status, clinic site, morbidity, HIV viremia and other factors in support of EHE partner initiatives' care engagement work and care navigation assignment to LINCS Navigators **Program Costs** arrived at by staff salaries and FTE required to successfully complete case investigation work required to determine necessity of LINCS Navigation case assignment. An acceptable portion of program operating and indirect costs are also included. **EHE Impact:** 300 cases and 1030 hours of case investigation in support of re-linkage to primary care and LINCS Navigation	**$83,794**	**$83,794**	**$ -**	**$ 83,794**

List of Contracts	Deliverables by HRSA HAB Service Category (service description)	Program Descriptions	FY2025 Allocated Funds	FY2025 Obligated Funds	FY2025 Expended as of 10/31/25	Anticipated Expenditure by end of 2025 Fiscal Year
Robert Whirry Consulting	**Planning and Evaluation** (Consultation Services)	**Consultation services** to support development and execution of a comprehensive evaluation of SFDPH HHS EHE Phase II Initiatives. **Program Costs** arrived at by consultant's hourly rate plus time required to collaborate with the HHS EHE Coordinator to develop and initiate implementation of an overall EHE evaluation plan. An acceptable portion of program operating and indirect costs are also included. **Work Plan Goal:** Development and delivery of a comprehensive EHE Initiative evaluation, in alignment with HRSA HAB EHE.	**$119,643**	**$0**	**$ -**	**$ -**
		TOTAL CONTRACTUAL COSTS	**$ 2,498,125**	**$ 2,378,482**	**$ 776,684**	**$ 1,601,798**

Administrative

Item	Category	Descriptions	FY2025 Allocated Funds	FY2025 Obligated Funds	FY2025 Expended as of 10/31/25	Anticipated Expenditure by end of 2025 Fiscal Year
SFDPH HIV Health Services Staff Salary	**Administrative** (SFDPH HHS EHE Coordinator)	Coordination, administration, evaluation and operation of health programs funded by EHE.	**$ 208,197**	**$ 208,197**	**$ 140,426**	**$ 67,771**
Travel	**Administrative** (Conference travel, SFDPH HHS Admin Staff)	Airfare, ground transportation, per diem, conference fees and related expenses for attendance at EHE-related conference to learn about other jurisdictions' efforts and share about EHE work in San Francisco	**$ 4,500**	**$ 4,500**	**$ 1,548**	**$ 2,952**
		TOTAL ADMINISTRATIVE COSTS	**$ 212,697**	**$ 212,697**	**$ 141,974**	**$ 70,723**

FY 2025 SFDPH HHS EHE TOTALS (FY 2025 Projected Unspent Funds: $119,643)	**$ 2,710,822**	**$ 2,591,179**	**$ 918,658**	**$ 1,672,521**