File No. 120089

Committee Item No. 2
Board Item No. _____

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget and Finance Committee **Date:** February 15, 2012

Board of Supervisors Meeting **Date** _____

Cmte	Board	
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☒	☐	**Resolution**
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OTHER **(Use back side if additional space is needed)**

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Completed by: Victor Young **Date:** February 10, 2012
Completed by: Victor Young **Date:** _____

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

[Accept and Expend Grant - San Francisco Minority AIDS Initiative - $1,352,141]

Resolution authorizing the San Francisco Department of Public Health to retroactively accept and expend a grant in the amount of $1,352,141 from the Substance Abuse and Mental Health Services Administration to participate in a program entitled "San Francisco Minority AIDS Initiative" for the period of September 30, 2011, through September 29, 2012, and waiving indirect costs.

WHEREAS, Substance Abuse and Mental Health Services Administration (SAMHSA) has agreed to fund San Francisco Department of Public Health (DPH) in the amount of $1,352,141 for the period of September 30, 2011 through September 29, 2012; and,

WHEREAS, The full project period of the grant starts on September 30, 2011 and ends on September 29, 2014, with years two and three subject to availability of funds and satisfactory progress of the project; and,

WHEREAS, As a condition of receiving the grant funds, SAMHSA requires the City to enter into an agreement (the "Agreement"), a copy of which is on file with the Clerk of the Board of Supervisors in File No.120089; which is hereby declared to be a part of this resolution as if set forth fully herein; and,

WHEREAS, The purpose of this project will target people at risk for or living with HIV/AIDS in its Centers of Excellence, which serve multiple minority populations and people with behavioral health needs; and,

WHEREAS, DPH will subcontract with UCSF AIDS Health Project, Haight/Ashbury Free Clinics-Walden House, and as yet to-be-determined entities in the total amount of $278,672 for the period of September 30, 2011 through September 29, 2012; and,

WHEREAS, An Annual Salary Ordinance amendment is not required as the grant partially reimburses DPH for nine existing positions, one Clinical Psychologist (Job Class No. 2574) at .33 FTE, one Psychiatric Social Worker (Job Class No. 2930) at 1.0 FTE, one Psychiatric Social Worker (Job Class No. 2930) at 1.0 FTE, one Psychiatric Social Worker (Job Class No. 2930) at 1.0 FTE, one Psychiatric Social Worker (Job Class No. 2930) at 1.0 FTE, one Psychiatric Social Worker (Job Class No. 2930) at 1.0 FTE, one Health Program Coordinator III (Job Class No. 2593) at 1.0 FTE, one Health Care Analyst (Job Class No. 2119) at 1.0 FTE and one Health Care Analyst (Job Class No. 2119) at 1.0 FTE, for the period of September 30, 2011, through September 29, 2012; and,

WHEREAS, A request for retroactive approval is being sought because DPH did not receive notification of the award until after September 30, 2011 for a project start date of September 30, 2011; and,

WHEREAS, San Francisco Minority AIDS Initiative grant does not allow for indirect costs to maximize use of grant funds on direct services; and

WHEREAS, The grant terms prohibit including indirect costs in the grant budget; now, therefore, be it

RESOLVED, That DPH is hereby authorized to accept and expend a grant retroactively in the amount of $1,352,141 from SAMHSA; and, be it

FURTHER RESOLVED, That the Board of Supervisors hereby waives inclusion of indirect costs in the grant budget; and, be it

FURTHER RESOLVED, That DPH is hereby authorized to retroactively accept and expend the grant funds pursuant to San Francisco Administrative Code section 10.170-1; and, be it

FURTHER RESOLVED, That the Director of Health is authorized to enter into the agreement on behalf of the City.

RECOMMENDED:

Barbara A. Garcia, MPA
Director of Health

APPROVED:

Office of the Mayor

Office of the Controller

City and County of San Francisco

Department of Public Health

Edwin M. Lee
Mayor

Barbara A. Garcia, MPA
Director of Health

TO: Angela Calvillo, Clerk of the Board of Supervisors

FROM: Barbara A. Garcia, MPA
Director of Health

DATE: November 16, 2011

SUBJECT: Grant Accept and Expend

GRANT TITLE: San Francisco Minority AIDS Initiative - $1,352,141

Attached please find the original and 4 copies of each of the following:

☒ Proposed grant resolution, original signed by Department

☒ Grant information form, including disability checklist -

☒ Budget and Budget Justification

☒ Grant application:

☒ Agreement / Award Letter

☐ Other (Explain):

Special Timeline Requirements:

Departmental representative to receive a copy of the adopted resolution:

Name: Richelle-Lynn Mojica Phone: 255-3555

Interoffice Mail Address: Dept. of Public Health, Office of Quality Management for Community Programs, 1380 Howard St.

Certified copy required Yes ☐ No ☒

File Number: _____
(Provided by Clerk of Board of Supervisors)

Grant Information Form
(Effective March 2005)

Purpose: Accompanies proposed Board of Supervisors resolutions authorizing a Department to accept and expend grant funds.

The following describes the grant referred to in the accompanying resolution:

1. Grant Title: San Francisco Minority AIDS Initiative

2. Department: Community Behavioral Health Services, Department of Public Health

3. Contact Person: Toni D. Rucker, Ph.D., Director of Grants, Training & Development
   Telephone: 415.255.3522

4. Grant Approval Status (check one):

   [X] Approved by funding agency [ ] Not yet approved

5. Amount of Grant Funding Approved or Applied for: $4,056,423 in the 3-year project period
   (Year 1 = $1,352,141; Year 2 = $1,352,141; Year 3 = $1,352,141)

6a. Matching Funds Required: 0
b. Source(s) of matching funds (if applicable): N/A

7a. Grant Source Agency: Substance Abuse and Mental Health Services Administration (SAMHSA)

b. Grant Pass-Through Agency (if applicable): N/A

8. Proposed Grant Project Summary: San Francisco Department of Public Health, with its partners at Haight/Ashbury Free Clinics-Walden House and the UCSF AIDS Health Project, will target people at risk for or living with HIV/AIDS in its Centers of Excellence, which serve multiple minority populations and people with behavioral health needs. SF DPH proposes three strategic initiatives that will serve 1,425 people annually and 4,275 over the life of the project.

9. Grant Project Schedule, as allowed in approval documents, or as proposed:

Approved Year one project:	Start-Date: 09/30/11	End-Date: 09/29/12
Full project period:	Start-Date: 09/30/11	End-Date: 09/29/14

10a. Amount budgeted for contractual services: $278,672 in Year 1
$858,356 in the 3-year project period

b. Will contractual services be put out to bid? Haight/Ashbury Free Clinics-Walden House- No;
UCSF AIDS Health Project- No; – State agency
Evaluation Team (TBD): Yes

c. If so, will contract services help to further the goals of the department's MBE/WBE requirements? Yes

d. Is this likely to be a one-time or ongoing request for contracting out? One-time

11a. Does the budget include indirect costs? [ ] Yes [X] No

b1. If yes, how much? N/A
b2. How was the amount calculated? N/A

c. If no, why are indirect costs not included?
[ ] Not allowed by granting agency [X] To maximize use of grant funds on direct services
[ ] Other (please explain):

12. Any other significant grant requirements or comments:

DPH respectfully requests for approval to accept and expend these funds retroactive to September 30, 2011. The Department received the agreement after September 30, 2011.

Grant index code: HMHSRCGRANTS
Grant code: HCSA10

****Disability Access Checklist*****

13. This Grant is intended for activities at (check all that apply):

[X] Existing Site(s)	[X] Existing Structure(s)	[ ] Existing Program(s) or Service(s)
[ ] Rehabilitated Site(s)	[ ] Rehabilitated Structure(s)	[X] New Program(s) or Service(s)
[ ] New Site(s)	[ ] New Structure(s)	

14. The Departmental ADA Coordinator and/or the Mayor's Office on Disability have reviewed the proposal and concluded that the project as proposed will be in compliance with the Americans with Disabilities Act and all other Federal, State and local access laws and regulations and will allow the full inclusion of persons with disabilities, or will require unreasonable hardship exceptions, as described in the comments section:

Comments:

Departmental or Mayor's Office of Disability Reviewer: _____ for Jason Hashimoto

Date Reviewed: 11/18/11

Department Approval: _____ for
Barbara A. Garcia, MPA (Signature) Director of Public Health

San Francisco Department of Public Health
Minority AIDS Initiative Targeted Capacity Expansion (MAI-TCE)
Budget for Year 1 (09/30/11-09/29/12)

A. Personnel

Position	Months	FTE	Salary	Budget
Mental Health				
Clinical Psychologist	12	0.33	$ 95,368	$ 31,471
Psychiatric Social Worker	12	3.00	$ 82,394	$ 247,182
Psychiatric Social Worker	10	2.00	$ 82,394	$ 137,323
Infrastructure:				
Health Program Coordinator III	12	1.00	$ 97,760	$ 97,760
Health Care Analyst	12	1.00	$ 79,664	$ 79,664
Evaluation:				
Manager I	12	0.20	$ 108,888	$ -
Health Care Analyst	12	1.00	$ 79,664	$ 79,664
Total Personnel				$ 673,065

B. Fringe	$	289,418
C. Travel	$	3,965
D. Equipment		
E. Supplies	$	13,000
F. Contract:		
HAFC-Walden	$	76,901
UC AIDS Health Project	$	172,691
Evaluation Team (TBD)	$	29,080
	$	278,672
G. Construction		
H. Other:		
Behaviorists Training	$	36,000
Clients Incentives	$	23,484
Clients Incidentals	$	27,537
Evaluation Incentives	$	7,000
	$	94,021
Total Direct Cost	$	1,352,141
Indirect Cost	$	-
Total Cost	**$**	**1,352,141**

San Francisco Department of Public Health
Minority AIDS Initiative Targeted Capacity Expansion (MAI-TCE)
Budget for Years 1-3 (09/30/11-09/29/14)

A. Personnel

Position	Salary	FTE	Year 1	Year 2	Year 3	Total Cost
Mental Health						
Clinical Psychologist	$ 95,368	0.33	$ 31,471	$ 31,471	$ 31,471	$ 94,414
Psychiatric Social Worker	$ 82,394	3.00	$ 247,182	$ 247,182	$ 247,182	$ 741,546
Psychiatric Social Worker	$ 82,394	2.00	$ 137,323	$ 164,788	$ 164,788	$ 466,899
Infrastructure:						
Health Program Coordinator III	$ 97,760	1.00	$ 97,760	$ 97,760	$ 97,760	$ 293,280
Health Care Analyst	$ 79,664	1.00	$ 79,664	$ 79,664	$ 79,664	$ 238,992
Evaluation:						
Manager I	$ 108,888	0.20				$ -
Health Care Analyst	$ 79,664	1.00	$ 79,664	$ 79,664	$ 79,664	$ 238,992
Total Personnel			673,065	$ 700,529	$ 700,529	**$ 2,074,124**
B. Fringe			289,418	$ 301,228	$ 301,228	**$ 891,873**
C. Travel			3,965	3,965	3,965	**$ 11,895**
D. Equipment			-	$ -	$ -	$ -
E. Supplies			13,000			**$ 13,000**
F. Contract						
HAFC-Walden			$ 76,901	$ 88,071	$ 88,071	$ 253,043
UC AIDS Health Project			$ 172,691	$ 172,691	$ 172,691	$ 518,073
Evaluation Team (TBD)			$ 29,080	$ 29,080	$ 29,080	$ 87,240
			$ 278,672	$ 289,842	$ 289,842	**$ 858,356**
G. Construction			-	$ -	$ -	$ -
H. Other						
Behaviorists Training			36,000			$ 36,000
Clients Incentives			23,484			$ 23,484
Clients Incidentals			27,537	$ 26,093	$ 26,093	$ 79,723
Evaluation Incentives			7,000	$ 7,000	$ 7,000	$ 21,000
			94,021	33,093	33,093	**160,207**
Total Direct Cost			1,352,141	1,328,657	1,328,657	**4,009,455**
Indirect Cost			-	$ -	$ -	**$ -**
Total Cost			**$ 1,352,141**	**$ 1,328,657**	**$ 1,328,657**	**$ 4,009,455**

San Francisco Department of Public Health
Minority AIDS Initiative Targeted Capacity Expansion (MAI-TCE)
Budget Justification for Year 1 (09/30/11-09/29/12) Budget Date 10/04/11

A. Personnel $673,065

Psychologist 0.33 FTE $31,472
The Clinical Psychologist will provide clinical oversight for MAI-TCE Mental Health Prevention and Treatment project staff as well as direct client services. The Clinical Psychologist is budgeted at .33 FTE in Years 1-3.

Psychiatric Social Worker 5.0 FTE $384,505
The Psychiatric Social Worker will be co-located in primary care settings and will be responsible for client assessments, consultative interventions, and providing skill training to MHTG participants. The Psychiatric Social Workers are budgeted at 4.67 FTE in Year 1 and 5.0 FTE in Years 2 and 3.

Health Program Coordinator III 1.0 FTE $97,760
The Health Program Coordinator III will be responsible for all aspects of the MAI-TCE project including developing collaborative relationships with governmental and community partners; coordination of activities between SFDPH, contractors, and collaborative agencies; oversight of client services and project evaluation; and hiring project staff. The Health Program Coordinator III is budgeted at 1 FTE in Years 1-3.

Health Care Analyst 1.0 FTE $79,664
The Health Care Analyst will be responsible for integration of data and analysis for MAI-TCE project management. The Health Care Analyst is budgeted at 1.0 FTE in Years 1-3.

Manager I .20 FTE $0
Toni Rucker, PhD, Director of Grants Training and Development, will oversee all aspects of the evaluation component including direct supervision of the Health Care Analyst. Dr. Rucker's LOE is 20% but it is not budgeted as a Federal Request.

Health Care Analyst 1.0 FTE $79,664
The Health Care Analyst will provide data cleaning and analysis functions for the Evaluation component of the MAI-TCE project. The Health Care Analyst is budgeted at 1 FTE in Years 1-3.

B. Fringe $289,418
Fringe benefits include employer's share of Federal, State, and local mandated payroll taxes; health, vision and dental insurance premiums; worker's compensation, unemployment, and disability insurance premiums; and employer's contribution to employee retirement plans. Fringe benefits are budgeted at 43% of personnel costs (salaries).

C. Travel $3,965

Funds are budgeted for two (2) staff to attend an annual 3-day grantee meeting in Washington DC and mileage for attending local meetings at $0.51 per mile. Travel expenses include roundtrip airfare, three (3) nights in a hotel, and ground transportation to/from San Francisco and Washington, DC area airports.

D. Equipment $0

E. Supplies $13,000

In Year 1, two (2) laptop computers will be purchased to be used by the Health Program Coordinator III and Health Care Analyst. Each computer will be equipped with a standard operating system, office software, and networking capabilities.

F. Contract $278,672

UCSF AIDS Health Project $172,691

UCSF AIDS Health Project will partner with SFDPH in the implementation of the MHTG project by employing and providing organizational support for the Outreach Case Managers and Client Support Specialists.

Haight Ashbury Free Clinics-Walden House $76,901

Haight Ashbury Free Clinics-Walden House will partner with SFDPH in the implementation of the MHTG project by employing and providing organizational support for the Outreach Case Managers and Client Support Specialists.

Evaluation Team (TBD) $29,080

The To Be Determined Evaluation team will assist the Health Care and Program Coordinator with data analysis and cleaning, assist COE, City Clinic, and Walden House clinical and program staff in tracking MAI participants, provide survey administration, data entry, and data record keeping, and contract follow-up interviews with MAI participants.

G. Construction $0

H. Other $94,021

Behaviorists Training $36,000

Funds are budgeted for training topics that address the core skills needed for Behaviorist role in an integrated primary care/behavioral health setting. Topics include: Brief Clinical Interventions, Clinical Domain Pathways, Documentation Skills, Consultation Skills, Team Performance Skills, and Practice Management.

Post NGA Supplemental Award
Client Incentives $23,484

With the supplemental funds received, CBHS will allocate incentive funds to increase Transgender participation in the SHOP Southeast component of the project. African American and Latino Transgenders will be targeted in outreach efforts by the funded Counselor and Health Workers. Supplemental grant funds will be allocated for bus tokens to attend group and individual counseling and recovery support efforts. Incentives will be offered for participants who meet with the Behaviorist and successfully complete at least 4 SHOP program efforts.

Client Incidentals $27,537

As determined necessary and appropriate by project management, MAI-TCE participants will be provided for transportation and very limited other incidental expenses.

Evaluation Incentives $7,000

Non-cash incentives such as gift cards will be provided to MAI-TCE participants in interviews and activities required for the Evaluation component.

Indirect $0

Section A: Statement of Purpose and Need

To better respond to the complex and interwoven health needs of San Francisco residents, the SF Department of Public Health (SF DPH) has undertaken a conversion of its primary care health care system to a new integrated primary care behavioral health model in which behavioral health is offered as part of routine and preventive care. This involves ensuring that the comprehensive needs of the individual are met, regardless of where and how they access the system ("Any Door Is the Right Door"). The client is the driver of his/her own care, and cultural competency is imbued throughout the system.

In implementing these changes, SFDPH has devoted considerable attention to the question of how to most effectively address the needs of complex, high acuity, homeless and other high-risk clients. Coordinating care for people at risk for or living with HIV/AIDS in minority populations is a key piece of its integration strategy. Each of the interventions proposed will improve service delivery to this population.

There are total of three initiatives that make up the proposed program.

The largest initiative proposed here is the addition of Behavioral Clinicians to San Francisco's HIV treatment centers, providing a full complement of behavioral health services in the clinics where the target population receives primary care and other assistance. These Behaviorists will be placed in clinics most likely to reach minority populations living with HIV. The purpose of the addition of Behavioral Clinicians is to treat mental illness and substance use disorders among those at risk for or living with HIV, and reduce the spread of HIV in minority populations in San Francisco. The purpose of the addition of Behavioral Clinicians is to treat mental illness and substance use disorders among those at risk for or living with HIV, and reduce the spread of HIV in minority populations in San Francisco.

In addition, San Francisco proposes to bolster its prevention efforts through offering substance use interventions to binge drinkers. Gay men, one of San Francisco's highest risk populations, will be the subject of directed outreach. The purpose of the UCSF AIDS Health Project (AHP) proposal is to provide effective outpatient services to HIV-negative and HIV-positive MSM of color with heavy alcohol use, which is strongly associated with HIV transmission, thereby improving the quality of life of the clients served by the project and helping prevent the spread of HIV in the community.

Finally, SF DPH proposes to expand the Southeast Health Opportunities Project (SHOP) program, which serves areas of the city with the highest minority concentrations. The purpose of the enhancement of the SHOP program is to reduce the spread of HIV infection and the use and abuse of illegal drugs, providing comprehensive, integrated services in a community that has historically shown resistance to Mental Health, Substance Abuse, and HIV services.

Goals and Objectives: This initiative will be implemented by San Francisco Department of Public Health (SF DPH), Community Behavioral Health Services (CBHS), and its community partners, the Haight Ashbury Free Clinic (HAFC), and the UCSF AIDS Health Project. The project's goals and objectives will be as follows:

Goal 1. Behavioral Health staff will engage members of the target population who have not accessed or followed through with behavioral health care services in the past.
Goal 2. Behavioral Health services will help clients stop abusing substances, improve or maintain their medical and mental health, and strengthen family and community support.

Program Outcomes:

1. 50% of all participants will show improved life skill, indicated by ability to conduct activities of daily living as clients will keep clinical appointment dates, measured by case management records.
2. 50% will have improved conditions of life, measured by NOMS/GPRA
3. 50% of SHOP and AHP clients with SUD will have decreased substance abuse, measured by NOMS/GPRA and case management records.
4. 50% of AHP clients will have decreased HIV risk behaviors, measured by case management records
5. 35% of all clients will have reduced number of sexual partners, measured by GPRA/NOMS
6. 100% of clients will participate in at least one additional service through San Francisco Minority AIDS Initiative, measured by case management records.
7. 100% of clients will have successful linkages to mental health and clinic-based services such as health care and behavioral health care, measured by case management records.
8. Each project year, a minimum of 60% of clients will show decreased symptoms of trauma as measured on the Trauma Symptom Checklist
9. Each project year, a minimum of 60% of clients will show a reduction in adverse behavioral health risk factors by engaging in PC/BH services (at least two interactions per month).
10. Each project year, a minimum of 60% of clients will reduce HIV risk and incidence by successfully working with a Behaviorist Clinicians (at least two interactions per month) moving them one step closer to health wellness and recovery.

The primary population served by each of the clinics at which Behavioral Clinicians will be stationed is as follows:

Centers of Excellence/City Clinic:

Chronic Care HIV/AIDS Multidisciplinary Program (CCHAMP): This CoE focuses on services to men who have sex with men (MSM); Latino, African American and transgender women; immigrants with a focus on undocumented Spanish-speaking persons. Service locations include the Mission/Potrero Hill area, South of Market, Upper Van Ness and Castro districts. The lead agency is the University of California in San Francisco: Positive Health Program at San Francisco General Hospital.

City Clinic: City Clinic is a specialty clinic which has been providing diagnosis and treatment of sexually transmitted diseases (STDs) to the San Francisco community since 1933. The Clinic is the City's only municipal STD Clinic and provides confidential, low cost, convenient drop-in services to all people over the age of 12, regardless of their ability to pay. Staff members speak English, Spanish, Russian, Cantonese, Mandarin and Tagalog.

Forensic AIDS Project: This CoE focuses on the coordination of care for HIV-positive incarcerated and post-release people and serves five San Francisco County jails. The lead agency is the San Francisco Department of Public Health.

Mission CoE: This CoE focuses on services for Latino/Latina populations, including monolingual Spanish speakers and immigrants, regardless of legal status. Service location is in the Mission District.

Native American CoE: This CoE focuses on Native Americans and Alaska Natives, including male, female and transgender persons. Service location is in the Mission District, where medical care is provided, with additional services in the mid-Market area.

Southeast Partnership for Health: This CoE focuses on services for underserved and uninsured African Americans, including women and transgender persons. Service locations are at UCSF, Positive Health Program at San Francisco General Hospital, and at UCSF: 360 at Parnassus.

Tenderloin Area CoE: This CoE focuses on homeless and marginally housed persons; active substance users; transgender persons; Asian/Pacific Islander groups; and prison populations. Service locations are in the Tenderloin.

Women's CoE: This CoE focuses on underserved and severe need women. Service locations are located at UCSF, Positive Health Program at San Francisco General Hospital, and at UCSF: Women's Clinic at Parnassus

SHOP: Mental health and Substance Use interventions will be added to the SHOP program, expanding its reach and numbers served. The Southeast Health Opportunities Project (SHOP), a service expansion and enhancement project, will serve the predominately African American residents of San Francisco's Bayview Hunters Point (BVHP), Mission District, Potrero Hill, and Sunnydale neighborhoods, all of which are impacted by mental illness, substance abuse, and HIV/AIDS. A recent review of a randomly selected chart at the Southeast Health Center showed a substance use/abuse prevalence rate of 32% while at the Potrero Hill Health Center, the rate was even higher at 48%.

Binge Drinking Prevention - AIDS Health Project (AHP)

AHP will provide outreach and intervention services in the following locations that target African Americans and Latinos:

UCSF *Men of Color Program* (primary care plus social services)

Mission Neighborhood Health Center's *Clinica Esperanza* program (primary care plus advocacy and education services)

All have funding to outreach to and assess the target population. Clients will also be identified by other programs of AHP, including:

Mental Health Crisis Team, and Outpatient Psychiatry and HIV Consultation-Liaison Psychiatry at San Francisco General Hospital (SFGH).

Acceptance Place: AHP currently facilitates a weekly group within Acceptance Place, a residential treatment facility for Gay and Lesbian clients. This setting would be another place to identify likely clients for referral.

Other Community Agencies: Black Coalition on AIDS, the Forensic AIDS Project, and the SF AIDS Foundation through its El Grupo and Black Brothers Esteem programs staff can send clients directly to the AHP site.

HIV-related disparities. Gay men, African American males who have sex with males (MSM), Latino MSM, and transfemales experience the greatest HIV-related disparities in San Francisco. Gay men represent the vast majority of HIV/AIDS cases and new infections. African American MSM are over-represented among HIV/AIDS cases compared with their numbers in the population. Latino MSM have higher rates of undiagnosed HIV compared with other groups. Transfemales have extremely high community viral load – 4 times the city average. (SF DPH Epidemiology)

Southeast Health Center and the Potrero Hill Health Center, the clinics in the SHOP neighborhood, are essential parts of the public system of care for the uninsured (39% and 32% of clients respectively at each clinic), with large client caseloads (17,030 and 11,622 client visits respectively last year). Two-thirds of the Southeast Health Center's patients are African American as are a third of the Potrero Hill Health Center's patients. The Southeast Health Center is in an area with some of the highest health disparities in San Francisco, with a high burden of poverty, diseases, and poor health outcomes. Chronic diseases, such as diabetes, hypertension, cancer, HIV infection, and asthma account for a significant cause of morbidity and mortality. These health problems are aggravated by substance use and abuse. (SF DPH)

As of 2011, an estimated 18,576 people are living with HIV/AIDS in SF (Raymond 2011). The populations most at risk for acquiring or transmitting HIV are males who have sex with males (MSM), injection drug users (IDU), and transfemales who have sex with males (TFSM). Together, these three populations represent 91% of HIV/AIDS cases (HES 2009) and an estimated 96% of the 723 annual new HIV infections in SF (Raymond 2011). Different behaviors and contexts drive HIV within each of these different populations. Unprotected anal sex is the primary behavior driving HIV in SF. Substance use has been directly linked to HIV seroconversion among MSM. Non-sexual behaviors, such as late and non-testing, treatment non-adherence among HIV-positive people, and missed HIV primary care appointments, also contribute to new infections. Interventions addressing these factors must also address discrimination and stigma, including racism and homophobia, which create an environment that is not supportive of healthy behaviors. (SF DPH Epidemiology)

Census Tract Information

Among men, the incidence rates of cases diagnosed with HIV are highest in African Americans. There was a declining trend in HIV case incidence rates for white men during 2006 to 2009, while incidence rates for men of other race/ethnicity groups remained fairly level in this time period. In 2009, the incidence rate of cases diagnosed with HIV per 100,000 population was 181 among African American men, 139 among Latino men, and 96 among white men. (2009 Annual Report on HIV/AIDS Epidemiology, San Francisco)

SF DPH examined the change in the number of newly diagnosed HIV/AIDS cases from 2006 through 2009 by neighborhood. The percentage change was calculated for each neighborhood as the difference in the number of cases diagnosed between 2006 and 2009 divided by the number of cases in 2006. Despite the overall decrease in newly diagnosed cases in San Francisco, some neighborhoods in the southern parts of the city report increasing numbers of cases from 2006 to 2009 (Bayview, Visitacion Valley, Outer Mission, and Sunset). In addition, newly diagnosed

homeless HIV/AIDS cases increased 13.5% during this time period. (2009 annual Report on HIV/AIDS Epidemiology, San Francisco)

Mental Health: Depression has been diagnosed in people living with HIV/AIDS at much higher rates than the general populations. This may be the result of difficulty coping with the illness, side effects of antiretroviral medications used to treat HIV/AIDS, or a combination of life factors and medication. Other factors associated with HIV infection such as a history of poverty, sexual abuse, domestic violence, homelessness, discrimination, racism, and stigma may also add to the risk of depression and other mental illness on a regular basis (Hooshyar, Napravink, Robertson, Fried, and Eron, 2003.)

The 2008 San Francisco HIV/AIDS Care Needs Assessment found that over a quarter of participants skipped their medication because they felt depressed or hopeless. In fact, 74.2 percent of surveyed respondents reported having been diagnosed with depression within the last two years (Exhibit 37). Over half or respondents have also been diagnosed with anxiety. One in four (27.7%) participants reported they had been diagnosed with bipolar disorder (Harder and Company, 2008.)

Substance Use: Substance use is a common co-morbidity associated with HIV infections. While substance use has many biological effects on patient's physical condition, it also may impair the judgment of the individual around risk behavior decisions, such as sexual risk and the risks associated with injection drug use.

In the 2008 SF Needs Assessment, substance use amongst survey participants varied by drug types. Among those who reported using any substances, 70 percent are current users, or have reported using at least one substance during the year. Alcohol and marijuana (37.0 percent reported to have a prescription for marijuana use) were most common. Among substances that are more commonly considered to be illicit, sixty-three percent of survey respondents have used crack/cocaine at least once, over half of whom currently used the drug. Similarly, 55.3 percent of respondents have used methamphetamines. The majority (63.5%) of these participants reported to have used the drug within the past year. Fourteen percent of survey participants reported that they injected hormones or steroids in the past year, none reported sharing needs. Twenty-five percent reported having injected street drugs in the past year, nine percent of who admitted sharing needles (Harder and Company 2008).

According to National HIV Behavioral Surveillance data, there are 65,000 MSM in San Francisco, and 48% of them (31,200) are between the ages of 21 and 35. The Plan states that 52% of MSM are heavy alcohol users, which suggests that there are approximately 16,200 (31,000 x 52%) heavy alcohol users between ages 21 to 35.Heavy alcohol use is considered a driver for HIV infection in San Francisco for two reasons: (1) Heavy alcohol use is considered prevalent (10% or higher) among populations at risk for HIV, and (2)the EXPLORE study with MSM found that heavy alcohol use was independently associated with twice the risk of acquiring HIV during the study (Koblin 2006).

Currently, SF DPH offers behavioral health services in the CoEs and through its partners at SHOP and AHP. The CoEs have a medical case management model to assist patients with treatment adherence and appointment follow-through, but the level of care is insufficient to meet the needs of those with more acute mental illnesses and substance use disorders. Similarly, SHOP provides behavioral health services, but can only expand its services in the Southeast and Mission communities through additional staffing. SHOP does currently provide outpatient

substance abuse treatment, but only to a small number of patients relative to the need in the community. AHP is pioneering the binge drinking prevention intervention in response to agency and system-wide identification of this high risk group. AHP provides behavioral health care to those already participating in services, but will reach a much broader population through this intervention.

Behavioral Clinicians in HIV Treatment Clinics:

This intervention is a strategy that promotes retention or re-engagement in care for HIV positive persons (ECHPP intervention #7) and treatment adherence (ECHPP intervention #9). Behavioral Clinicians would centralize these responsibilities, and allow for the highest risk individuals to receive ongoing, intensive, one-on-one services to keep them engaged in care and adhering to medications. The behavioral clinician will address a wide range of barriers to engagement/adherence, including mental health and substance use issues. They would also address other behavioral factors for co-occurring issues, such as heart disease, diabetes, etc., but would be specialists in HIV. The Behavioral Clinicians also address #17 (evidence based prevention interventions for HIV positive patients) through individual and group counseling.

Southeast Health Opportunities Program (SHOP) Expansion:

Similar to the Behavioral Clinician expansion, SHOP is a strategy that promotes retention or re-engagement in care for HIV positive persons (ECHPP intervention #7) and treatment adherence (ECHPP intervention #9). It also addresses #24 (community mobilization) through community outreach and engagement activities, and #17 (evidence based prevention interventions for HIV positive patients.) In SHOP, these activities will be conducted in the Bayview Hunters Point neighborhood, where there are large concentrations of at-risk minority and very low-income residents.

AIDS Health Project (AHP) Binge drinking intervention for MSM:

The SF ECHPP Plan addresses intervention #13 through the provision of behavioral risk screening followed by risk reduction interventions for HIV positive persons. It also addresses #23 (brief alcohol screening and interventions). Currently, there are no services in SF for MSM who binge drink, despite the scientific evidence that this issue one of just a handful of issued driving the HIV epidemic in SF. The proposed AHP service will fill this large gap in the ECHPP Plan, and will help to raise community awareness about the issue of binge drinking in addition to providing services.

Section B: Proposed Plan for Service

HIV Specialized Behavioral Clinicians in Centers of Excellence will focus on behavioral health treatment among HIV+ persons with mental health and substance use disorders. Currently, the COEs serve hundreds of clients per year who suffer from behavioral health disorders and are seeking treatment. This intervention will provide clinical staff to serve COE clients through the Mission Mental Health and South Van Ness Mental Health clinics. Five Behavioral Clinicians will provide on-site intake and case coordination services to engage clients most at risk, then link clients to the Mental Health Clinics for access to individual and group therapy services. The behavioral Clinicians will be overseen by the Clinical Supervisor, a new position within DPH for HIV specific clinical interventions.

The SHOP Expansion will build on a proven practice for engaging clients in the Southeast section of San Francisco, where clients are often reluctant to engage in services. By providing

additional outreach, case management, clinical interventions, and substance abuse counseling, SHOP will further decrease the spread of infections in the Bayview Hunters Point and surrounding neighborhoods.

AIDS Health Project will provide outreach and clinical interventions for HIV+ and persons at risk for HIV to combat new infections correlated with binge drinking. When MSM of color are identified in the community, and heavy alcohol use is also identified, clients will be referred for services responsive to their HIV status.

SF DPH has created an infrastructure plan that will greatly increase the level of coordination throughout the department and the community. In the Community Programs Section of the department, SF DPH will create a Director of HIV Community Services, to ensure that ECHPP planning is implemented in its community clinics, substance abuse and mental health services, and housing activities. This new Director will Co-Chair the ECHPP Community and Provider Planning Group and will oversee the project implementation, including the contract work provided by Walden House and AHP. Reporting to the Director of HIV Community Services will be a Clinical Supervisor, who will provide direct supervision of the Behavioral Clinicians. Finally, a Data Analyst position will be added to ensure uniformity in data gathering and reporting in collaboration with ECHPP.

San Francisco currently provides an array of services. In addition, SF DPH proposes to add these critical service components. The breakdown of required services for this target population is outlined below:

Required Services

Requirement	SAMHSA Proposed	Other Provision
Building emotional health, preventing or mitigating complications from MH or SUD (health education, wellness, risk reduction	Behavioral Clinicians, SHOP, AHP	
Outreach and treatment for MH and SUD, screening, toxicology screening for AOD, assessment, individual treatment planning	Behavioral Clinicians, SHOP, AHP	
Intensive case management aimed at retention in treatment	Behavioral Clinicians, SHOP, AHP	
Recovery support services	Behavioral Clinicians, SHOP, AHP	
Referrals for STI, hep AB(including immunization)C, and TB testing		COEs
Referrals to permanent housing that supports recovery for individuals within priority populations who have MH or SUD and would otherwise be homeless		Housing and Urban Health

MAI-TCE proposed elements:

Behavioral Clinician Component

Behavioral Clinicians will conduct intakes within the CoEs, screening referrals for their need for behavioral health services. Clinical staff will serve COE clients through the Mission Mental Health and South Van Ness Mental Health clinics. Five Behavioral Clinicians will provide on-site intake and case coordination services to engage clients most at risk, then link clients to the Mental Health Clinics for ongoing individual and group therapy services. The behavioral Clinicians will be overseen by the Clinical Supervisor, a new position within DPH for HIV specific clinical interventions.

The Behavioral Clinicians will work through the Centers of Excellence, with two Mental Health clinics as their clinical homes. As a result, a wide variety of primary care and behavioral health services are available.

Clinical Home

The Mission and South Van Ness Mental Health Clinics are advanced access clinics. They provide clinic based wrap-around psychiatric services such as psychiatric evaluation, psychiatric medications, Clinical Case Management, outreach, therapy, crisis intervention and urgent care, Buprenorphine Outpatient Opioid Treatment and group treatment for substance abuse harm reduction, anxiety/stress reduction, DBT treatment, smoking cessation.

CoE Program Service Components

Centers of Excellence (CoEs) share a common set of services including:

- Primary HIV medical care
- Case management
- Outpatient mental health
- Outpatient substance abuse
- Treatment advocacy

Each CoE additionally has specialty services, which vary by location. CoEs vary in terms of size, location and expertise in the needs of specific populations. Any qualifying client may receive services in the CoE of his / her choice, and will thereby have access to one of the two clinical homes.

Integrated Care Plan

Short-term client care plan objectives are discussed with the patient at the end of the psychosocial assessment. These include scheduling the patient for a medical examination and lab tests, counseling as needed, and immediate referrals for food, housing and General Assistance that would stabilize the patient sufficiently to pursue health care. Long-term patient care plan objectives include HIV status disclosure, safer sex practices, psychotherapy, on-going supportive counseling, management of health issues, initiation and adherence to antiretroviral medications, referrals to HIV support groups, dental care, legal assistance, assistance with durable power of attorney paperwork, and stress management. Referrals are only made with the approval of the patient.

Primary Care

Primary care services in the CoEs are tailored to meet the needs of people living with HIV/AIDS. The primary health care provider conducts immune system monitoring by ordering lab tests according to established protocols. Patients are offered access to comprehensive diagnostic and therapeutic services to determine HIV disease stage, and to prevent and treat the deterioration of the immune system and related conditions. Provision of primary care services is documented in patient's chart, which also includes an updated active medication list. The primary care provider monitors all laboratory results.

Continuing patients receive medical care, in general, every three months. Several weeks prior to these appointments, patients have blood drawn for laboratory work-up. At these appointments, patients receive a comprehensive history and physical examination, and any appropriate STD screening tests. Patients discuss their medical status and any new symptoms that may have developed or changes that may have occurred with the clinician, and receive results of recent lab tests.

SHOP Program

SF DPH's partner in this project, HAFC/Walden House has an on-site Mental Health Therapist through SF DPH, and a contract with Human Services Agency for Differential Response to address domestic violence and substance abuse for families. These relationships will be leveraged to provide additional supports for clients and allow WH staff to interface with providers throughout the City. With the complexity of life issues for targeted clients, this vast network is needed to adequately support the recovery process for the targeted SHOP clients, many who have complex health and social needs. Contacting and collaborating with community-based organizations in San Francisco that serve low-income clients are a part of SHOP efforts to expand SHOP capacity to serve the target population.

AHP

AHP offers a full spectrum of behavioral health services from its 15,000 square foot Client Services facility located at 1930 Market Street and through its community and mobile services. The services provided include HIV/STI counseling and testing; substance use counseling/case management; individual and group risk-reduction counseling; individual and group psychotherapy, psychiatric care (medication assessment and monitoring), mental health crisis services, neuropsychological testing; and HIV dementia coordination. AHP will conduct outreach and ensure engagement in a variety of ways to reach the clients for whom heavy alcohol use increases the risk of contracting or transmitting HIV. Depending on the serostatus of the client they will be provided a single session Personalized Cognitive Counseling (PCC) intervention or receive treatment within our existing AIDS and Substance Abuse Program (ASAP) which uses Motivational Interviewing for people with a range of substance abuse problems.

Primary Care Behavioral Health Integration has a growing body of evidential support. Integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health care they need. (WHO 2008) Co-location of the Behavioral services in the Primary Care setting, then creating a specialty referral into the mental health clinic for ongoing behavioral health care is recommended in order to

increase the availability of psychotherapeutic options. (Agency for Healthcare Research and Quality, 2008)

The NIDA Community-Based Outreach model has been evaluated in many controlled studies of culturally diverse out-of-treatment drug users (Coyle, Needle, Normand, 1998). Combining it with motivational interviewing or conflict resolution skills training appears to increase its effectiveness. In a study with African-American women who injected drugs, adding two more sessions to build motivation or develop conflict resolution skills helped all participants stop sharing needles, versus 13% sharing needles after the standard CBOM intervention (Sterk, 2003). This model will be used in the SHOP program.

The primary reason for the selection of this model is that it starts with outreach and referral. This is especially needed in communities where survival needs, resistance to structure and accountability, avoidance of stigma, work against openness to substance abuse treatment and HIV testing. Without outreach and referrals to other needed services, few residents in our targeted communities would self-regulate and adhere to treatment structures or decide to get HIV tested on their own. Another reason for the selection of this model is that it is designed for participants who are not yet receiving health care or drug treatment. Finally, it is designed for both the clinic and community settings that are part of in the proposed project. It involves peer opinion leaders as well as community leaders necessary for diffusion of the innovation throughout the community (Rogers, 1983).

Strengths-based case management (SBCM) helps participants develop skills across a number of life domains, such as job skills training (e.g., resume development, interviewing skills, relationship skills training (e.g., anger management), and health efficacy and empowerment e.g., understand chronic illness such as hypertension, medication management, and cultural modes of physical activity) . Strengths-based case management has been has been evaluated in randomized trials with similar drug using populations. In one randomized trial in a drug treatment program for veterans (72% African American, 65% with a prior conviction, 43% cocaine users) (Siegal, Fisher, Rapp, Kelliher, Wagner, O'Brien, Cole, 1996; Siegal, Li, Rapp, 2002), participants who received SBCM ended up with more employment, higher functioning in a number of life domains, fewer legal problems, and more aftercare participation than participants who received no case management. Helping clients work toward their life goals using strengths-based case management is relevant to drug use and HIV risk. Attaining social stability reduces the risk of developing or worsening substance dependence (Vaillant, 2003). Improving employment and relationships addresses important survival needs (e.g. obtain stable housing, or leave a violent relationship), and thereby reduces need to engage in risky behaviors (e.g., providing sex in exchange for a place to stay). SBCM will be used in the SHOP program.

Motivational interviewing was developed in response to the common problem of low client motivation to stop using substances (pre-contemplation stage). It is a counseling approach that elicits the participant's change process. Motivational interviewing has been evaluated in numerous randomized studies with diverse drug using populations. A meta-analysis of 72 clinical trials found that motivational interviewing led to more change in substance use (Hettema, Steele, Miller, 2005). Notably, larger effect sizes were found with ethnic minority clients, and when the motivational interviewing was not manual driven. Motivational interviewing is a flexible approach that can address culturally relevant content. In one randomized study, African-American drug users (mostly cocaine users) who received motivational interviewing relating their drug use to African-American community concerns were less likely to be using drugs at

one-year follow-up than were those who received substance abuse assessment and referral (54.3% versus 70.5%) (Longshore & Grills, 2000). It was selected over the more structured motivational enhancement therapy (MET) because of the finding by Hettema et al. (2005) that flexible motivational interviewing had larger effects than manual-driven approaches like MET. Motivational interviewing is used by SHOP and AHP.

The *Seeking Safety* model (www.seekingsafety.org) for treatment of trauma and substance abuse is a trauma-informed cognitive-behavioral treatment (CBT) designed for group and/or individual counseling. *Seeking Safety* helps participants identify whether their drug use is causing them problems. In addition, it helps them develop safe coping skills for intense emotions, symptoms of Post-Traumatic Stress Disorder (PTSD), and drug-related triggers. The curriculum acknowledges both physical and sexual assault in a safe, contained way that does not increase the risk of relapse. Such trauma-informed treatment is essential when working in the neighborhoods like BVHP, where chronic violence has resulted in multiple losses, and presents a continuing threat to safety. In addition, *Seeking Safety* is relevant to men and women who have served in the military, where they may have experienced combat related trauma, or physical or sexual assault.

In a randomized trial with urban, low-income women who had substance use disorders and PTSD (Hien, et al., 2004), participants who were assigned to a *Seeking Safety* program had comparable reductions in substance use and psychiatric symptoms, and both were lower than a comparison group that received referrals only. *Seeking Safety* also has good acceptability and outcomes with men (Najavits et al., 2005), including male veterans (Weaver, et al., 2007). This version of CBT can be implemented in a flexible session order, and thus participants who miss sessions do not fall behind. *Seeking Safety* will be used as the main model, and supplemented with exercises and worksheets from Matrix or other CBT models (e.g. relapse prevention group handouts). *Seeking Safety* will be used in the Mental Health Clinics and at SHOP.

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment method that incorporates a behavioral, problem-solving focus with change acceptance strategies. DBT has four components for patients: mindfulness (attention to one's experience), interpersonal effectiveness, emotional regulation, and distress tolerance. It was originally created by Dr. Marsha Linehan from the University of Washington to help women with borderline personality disorder and has now become a leading form of treatment for people who have experienced trauma, depression, addiction and more. Multiple randomized controlled trials conducted across five research institutions have evaluated DBT. The results support DBT's efficacy in reducing a number of behavioral problems, including suicide attempts and self-injurious behaviors (Micheff and Linehan 2008, citing Koons et al., 2001; Linehan et al., 1991, 2006; Linehan, Heard, and Armstrong, 1993; van den Bosch et al., 2005; Verheul et al., 2003). DBT individual and group services will be used by the Behavioral Clinicians.

Personalized Cognitive Counseling (PCC) is a brief, feasible and flexible intervention that is well suited for broad dissemination and for delivery in variety of settings and client presentation scenarios. Specifically designed for high risk HIV-negative MSM, PCC is a client-centered intervention delivered in a single session in conjunction with standard HIV test counseling. Clients complete a "self-justification" questionnaire based on a recent episode of unprotected anal intercourse (UAI) with a male partner of unknown or known HIV-positive serostatus. Questions reflect self-justifying thoughts associated with having sex without a condom. After a client completes the questionnaire, the counselor asks the client to describe the events, and his specific thoughts and feelings before, during, and after the encounter, in as much detail as

possible. Counselor and client then discuss identified self-justifications and develop a client-specific plan for addressing similar situations in the future. PCC has been delivered effectively by both mental health professionals and by paraprofessional counselors. The efficacy and effectiveness of PCC have been demonstrated in two NIMH-funded randomized trials. In the first trial, 248 HIV-negative MSM who reported UAI and an HIV test in the prior 12 months were randomized to receive standard HIV counseling alone or in combination with PCC (delivered by mental health professionals) and to complete a 90-day sexual diary or not.(Dilley, Woods, Loeb 2007) Compared to standard counseling, PCC was associated with larger and more sustained reductions in UAI. The proportion of PCC participants reporting UAI dropped from 66% at baseline, to 21% at 6 month follow-up and 26% at 12-month follow-up ($p<.01$). The diary intervention had a modest impact on outcomes, but had no incremental effect beyond that of PCC.

In the second trial, PCC (delivered by paraprofessional counselors) in combination with standard counseling was compared to standard counseling alone in a sample of 336 HIV-negative MSM. (Dilley, Woods, Sabatino, 2002) While at baseline both groups reported similar numbers of episodes of UAI in the previous 90 days (4.2 and 4.8), at 6-month follow-up, those receiving PCC reported an average of 1.9 episodes of UAI, while those receiving standard counseling alone reported an average of 4.3 episodes ($p=.03$). At 12-month follow-up, PCC participants reported sustained reductions in risky sexual behavior, with an average 1.9 episodes of UAI, while standard counseling participants also reported lower levels of UAI than at baseline, with an average of 2.2.

A follow-up analysis showed that PCC is similarly effective for men of color and for white men. The reduction in UAI associated with PCC in this study (approximately 3 episodes in a 90 day period) suggests substantial decreases in personal risk for acquiring HIV. One simulation study suggested that a single unsafe sexual partner per person per year can impact community prevalence of HIV. (Morris, Dean 1994)

Based upon the empirical data described above, the CDC has designated PCC as an EBI, and funded the development of standardized training methods and materials through its Replicating Effective Programs process. Nationwide CDC-sponsored training will begin in July 2011. PCC will be used by AHP.

As described in more detail in the program description above, intensive case management will be provided in all three components of the proposed programs. Behavioral Clinicians will provide ongoing individual and group services to a caseload of 25 people per HIV center with HIV from the target population. SHOP will provide ongoing intensive clinical and substance use services to its population as long as the patients remain enrolled. AHP will provide ongoing PCC and MI to its patients.

CoE/MH Behavioral Clinicians

The CoEs provide HIV Care services to individuals who test positive for HIV any of the Community Health Care Clinics or other testing sites. Patients who test positive for HIV are asked about county of residence and access to medical care and are given referrals as appropriate. Those patients who are San Francisco residents and are uninsured or underinsured are informed about the CoE Program by a counselor during a risk assessment and disclosure counseling session, and are offered the opportunity to participate in the CoE, as capacity allows. Behavioral Clinicians will work as part of the team within the CoE sites, and will administer

Duke Health Profile for mental health and substance abuse service needs. As a result of those assessments, primary care referral, and other service usage data, clients will be enrolled in the clinical home as part of the Behavioral Clinician's caseload.

SHOP

SHOP will contact the target population in parks and other areas where they "hang out," moving about in cars, vans and even on "foot patrols." This is critical, since the target population in this service area tends to cluster in places of activity, legal and otherwise, including shared housing, street corners, under freeway overpasses, and drug trafficking sites. Outreach events will also be conducted at San Francisco Housing Authority's residential properties in the targeted neighborhoods. Afternoon, evening, and weekend door-to-door, person-to-person distribution of program activities will take place at these properties. Some additional prospective SHOP participants will be identified when they seek medical care at neighborhood health clinics serving the target population. Patients identified with a substance abuse issue at the Southeast and Potrero Hill Health Centers will be served in SHOP by a project-funded Nurse Case Manager and Health Worker who will work at both clinics. They will also connect clients with community groups supportive of recovery (such as 12-step meetings, SMART recovery meetings, churches) and refer them to specialized substance abuse treatment programs, including those to be offered under SHOP, as well as other CBHS funded programs such as residential detoxification/treatment and buprenorphine/ methadone maintenance.

AHP

As a large HIV testing site within a behavioral health clinic, we are confident that HIV-negative MSM of color who describe heavy drinking during testing can be routed to counselors skilled in the PCC intervention. Within its behavioral health services is a SAMSHA CSAT funded program in its fourth of five years titled, AIDS and Substance Abuse Program (ASAP) for African Americans and Latinos with HIV/AIDS. The collaborating agencies within this program include, the UCSF *Men of Color Program* (primary care plus social services), Mission Neighborhood Health Center's *Clinica Esperanza* program (primary care plus advocacy and education services), and *Women's Center of Excellence in HIV Care (CoE)* (collaboration of agencies serving women with HIV including primary care, social services, and housing). All have funding to outreach to and assess the target population. Clients will also be identified by other programs of AHP, including the Mental Health Crisis Team, and Outpatient Psychiatry and HIV Consultation-Liaison Psychiatry at SFGH. AHP currently facilitates a weekly group within Acceptance Place, a residential treatment facility for Gay and Lesbian clients. This setting would be another place to identify likely clients for referral. Finally, referrals will be made by other community agencies such as the Black Coalition on AIDS, the Forensic AIDS Project, and the SF AIDS Foundation through its El Grupo and Black Brothers Esteem programs. Referring agency staff can send clients directly to AHP site when appropriate.

SFDPH promotes significant participation of consumers and family members in all aspects of the mental health system and in all levels of responsibilities. At the service level, SFDPH encourages consumer participation in development of treatment plans that takes into consideration the individual's strength, goals, cultural background, and social beliefs. At a planning and implementation level, SFDPH supports the involvement of consumers and family members in stakeholders' planning, policy development, implementation of programs and services, and

evaluation. For this project, the Evaluator will participate in peer feedback meetings to gather input on the implementation.

Coordinating Body: Community members to participate in the CPPG already serve on existing HIV planning groups and were selected because of their HIV experience and expertise. Participating HIV providers were selected to provide services through competitive request for proposals processes. They were required to have at least 2 to 3 years of experience with HIV service provision, and most have 10 or more.

Client Surveys: A locally developed survey will be distributed periodically to all clients to assess client satisfaction. The results will be reviewed by the Project Coordinator and discussed with the project staff to determine the program's strengths and weaknesses and to identify areas that need improvement.

As a supplement to *Seeking Safety*, cognitive-behavioral treatment will draw material from the *Matrix Intensive Outpatient Treatment for Stimulant Use Disorders*. The SAMHSA CSAT manual for the Matrix Intensive Outpatient Treatment for Stimulant Use Disorders offers simple, user-friendly client handouts focused on stopping substance use and preventing relapse for use in group, individual, and family sessions.

The interventions selected have evidence of effectiveness on the outcomes of interest in similar populations and follow recommendations from focus groups conducted in the communities served (Harder + Company, 2003.) The content is culturally appropriate, and is flexible enough to allocate additional focus to the areas of most concern to the communities served. Group curricula (e.g. *Seeking Safety*) can be implemented in a drop-in and rolling-enrollment format, thereby minimizing waiting times, and accommodating participants who have barriers to consistent attendance.

Intervention	YEAR 1	YEAR 2	YEAR 3	TOTAL
Behavioral Clinicians	225	225	225	675
SHOP	50	50	50	150
AHP	200	200	200	600

Type of Service	Year 1	Year 2	Year 3	Total
Outreach	1000	1000	1000	3000
Case Management	375	375	375	1125
Treatment	300	300	300	900
TOTAL	**1675**	**1675**	**1675**	**5025**

Outcomes

1. Each project year, a minimum of 60% of clients will show decreased symptoms of trauma as measured on the Trauma Symptom Checklist
2. Each project year, a minimum of 60% of clients will show a reduction in adverse behavioral health risk factors by engaging in PC/BH services (at least two interactions per month).
3. Each project year, a minimum of 60% of clients will reduce HIV risk and incidence by successfully working with a Behaviorist Clinicians (at least two interactions per month) moving them one step closer to health wellness and recovery.

Service delivery will begin within four months of notification, as indicated in the Timeline, below.

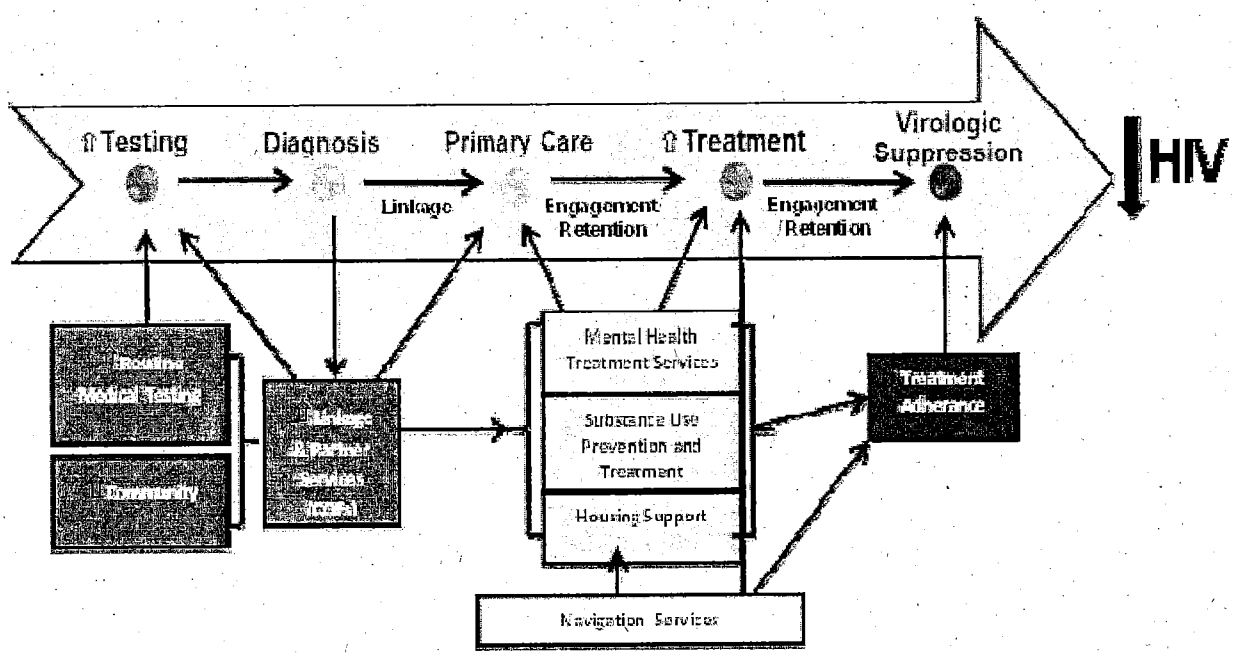
SF DPH will establish its BH/PCNC through collaboration with the HIV Prevention Planning Council and HIV Health Services Planning Council. The membership of these two groups encompasses nearly all the stakeholders who need to be involved in in the BH/PCNC, and plans to add additional representatives as needed are in progress. Because services will be provided in existing clinics and agencies, very little must be done to prepare the facilities. The COEs already work in a unified model, and have working relationships with the mental health homes to be used. The SHOP and AHP programs are in existing service sites and have the infrastructure in place to supplement their staffing with these additional program components. The Community Providers Planning Group is already formed and will incorporate the new Director of HIV Services as co-chair in a seamless manner.

Section C: roposed Plan for Infrastructure Development

SF's ECHPP integrates the ECHPP interventions into a seamless Continuum of Prevention, Care, and Treatment for people living with and at risk for HIV. SFDPH will use these funds, and other funding streams, to strengthen and de-silo its existing infrastructure to better integrate programs, funding, and data. SFDPH sections will work together to plan, implement, and evaluate the Continuum. Community engagement will be a critical component of the ECHPP roll-out, including the active participation of multiple stakeholders – such as the HPPC, HSPC, and HIV service providers.

SF's ECHPP clearly outlines the vision for this Continuum, but coordination and collaboration will be needed at all levels and among multiple stakeholders in order to make this vision a reality. The chart below shows how the Continuum, when fully implemented will *reduce new HIV infections.*

SF Continuum of HIV Prevention, Care, and Treatment



SF will build on and enhance the capacity of established systems and processes to create the following infrastructure for expanding, implementing, and evaluating the SF ECHPP:

Director's Cabinet on HIV/AIDS. The existing SFDPH Director's Cabinet, led by the Director of Health, consists of the Directors of key sections of the health department. The Cabinet will dedicate one annual meeting to review local indicators for HIV/AIDS and plan for shifts in course, and will serve as liaison to the Health Commission, the governing and policy-making body for SFDPH.

SFDPH ECHPP and MAI-TCE Implementation Committee. Now that the planning phase is over, the ECHPP Planning Committee will reconvene as the ECHPP Implementation Committee, and will include an expanded list of SFDPH staff with programmatic and data expertise. The Committee will convene quarterly to: 1) review HIV-related data from multiple data systems and sources, funder progress reports, monitoring and evaluation data from various grants, federal independent evaluations of the NHAS) on an ongoing basis in order to identify unmet needs, evaluate health outcomes, and monitor progress towards meeting ECHPP goals and objectives. The Committee will also work closely with the ECHPP Community and Provider Planning Group (see below) to integrate this behavioral health component into the ECHPP (per the requirements of the MAI-TCE grant) and to expand the ECHPP beyond a prevention lens to include additional goals and objectives for people living with HIV/AIDS that relate to the NHAS goals.

ECHPP Community and Provider Planning Group (CPPG). This group's primary role will be to work closely with the ECHPP Implementation Committee to guide roll-out of the ECHPP activities. This group will also serve as the BH/PCNC, because the overall goals and objectives are complementary. The CPPG will convene four times a year and will be held in place of

regular HPPC and HSPC meetings to reduce meeting burden. Specifically, membership on this CPPG will include representatives from: HPPC, HSPC, HIV service providers, community-based mental health and substance use providers, and individuals living with and at risk for HIV.

Required Infrastructure Activities

Requirement	SAMHSA Proposed	Other Provision
Incorporate behavioral health services into ECHPP implementation plans	The Community Provider Planning Group, Co-chaired by the proposed Director of Community HIV Services	ECHPP Director will have oversight responsibility for ECHPP plan, including behavioral health components.
Address existing gaps in BH and related support services and/or realign resources to address the prevention and treatment of MH and SUD	The CPPG, with the Community Programs representation, will bring MH and SUD provider perspective to the ECHPP. Significant training resources will improve capacity for treatment.	
Development of integrated and enhanced referral systems with public health, primary care, community based agencies – (may include MIS)	Behavioral Clinicians will connect the COEs with the Mental Health Clinics	
Training and workforce development for PC and BH staff, including use of EBP for prevention and treatment of MH and SUD, and/or training of HIV/AIDS Care Coordinators	SF DPH proposes extensive training in EBP for the Behavioral Clinicians who will specialize in HIV services.	
Development of a BH and PCNC, which must be co-chaired by applicant	The CPPG will be co-chaired by the Community Programs HIV Services Director	

As each intervention is designed to build on existing effective programming (Integrated Care, CoE services, SHOP services, and AHP programs), the new components will naturally embed in the provider agencies. The Behavioral Clinicians will coordinate most directly with the Medical Case Managers at the CoEs, and their Clinical Supervisor in the Mental Health Clinic. The SHOP staffing will be directly integrated as an expansion of existing services with an enhanced level of substance abuse treatment. The AHP intervention will add an intensified outreach and treatment component to an existing community-based program serving a similar population.

Another tool to seamlessly integrate the proposed services will be the addition of significant training support for the participating agencies. DBT, Seeking Safety, PCC, and Substance Abuse

interventions will be taught to the Behavioral Clinicians, the SHOP and AHP staff, and potentially members of the CoE staff, such as the Medical Case Managers.

There are two major components that will assist with coordination of MAI-TCE funds with other Federal sources. First, the MAI-TCE funded Project Director will work directly with HIV Planning Council to coordinate the entire SF HIV prevention effort. Secondly, the project funded Data Analyst will be tasked with delivering analyses of the target population for outreach, engagement, service, follow-up and evaluation. This is project management data, quite distinct for the required NOMS Evaluation, even though the two will need to work closely to coordinate data sources and processing.

The core of the needed management analyses include target population descriptions, penetration analyses, risk indices, demographics, engagement profiles, individual service data, sub-program productivity data, client outcomes, and system outcomes. The data to be woven into these analyses comes from multiple, ongoing collection systems, all at lest partially funded by Federal sources. Existing, non-coordinated data sets include those for Center for Substance Abuse Treatment, Center for Substance Abuse Prevention, Center for Mental Health Services, CDC HIV Prevention, HRSA HIV Health Services, Medi-care eligibility and billing data, Medicaid/Medi-Cal eligibility and billing data, California Department of Alcohol & Drug Programs CalOMS, California Department of Mental Health CSI Data Set, California Office of AIDS Data Set, California Department of Health Care Services billing data, California Department of Managed Care Services billing data. As California faces returning unprecedented numbers of inmates and paroles back to the county, we will incorporate data from Superior Court, California Department of Corrections, and County Probation.

SF also has a solid start on managing multiple data sources through the Coordinated Case Management System, CCMS, run by the Deputy Director of Public Health, Marina Martinez. The CCMS send a regular electronic query to each of the member data bases, establishes identity, and provide a type of consolidated data warehouse. CCMS is evolving, and a portion of this project is use of the CCMS, and participation in development in consideration of the service patterns of HIV risk, prevention and treatment that cross all of our mandated systems. Currently CCMS would allow and HIV Prevention Case Manager to both duplications and gaps in service for most participating clients as those clients engage in multiple health and social services. Current development is a project to develop automated risk, vulnerability and acuity measurements across a much wider group of individuals and service types than has been previously available.

Haight Ashbury Free Clinics: HAFC is a newly merged organization that combines the legacy of the nation's first free medical clinic (HAFC, founded in San Francisco, 1967) and the expertise of a leading behavioral health organization, Walden House (WH, founded in San Francisco, 1969) to form a comprehensive, integrated Federally Qualified Health Center (FQHC) poised at the leading edge of healthcare reform. The merger is near complete; the agencies operate under one board of directors, one executive team (formerly the WH executive team), and one administrative structure, and the changes required to transfer WH contracts, licenses, and business registrations to HAFC are in process. Because HAFC has existing FQHC status, the merged organization will retain the HAFC Federal Tax ID and 501(c)3 registration, as well as the HAFC FQHC registration, though WH programs, staff, and infrastructure will represent more

than three quarters of the merged agency's operations and budget (approximately $50 million, with 465 full time employees.) HAFC will be the lead provider in the SHOP component

AIDS Health Project

Since 1984, AHP has used the epidemiology of the HIV epidemic in SF along with the guidance of SFDPH to target its HIV prevention services. Serving more than 8,000 clients annually, AHP offers a full spectrum of behavioral health services from its 15,000 square foot Client Services facility located at 1930 Market Street and through its community and mobile services. The services provided include HIV/STI counseling and testing; substance use counseling/case management; individual and group risk-reduction counseling; individual and group psychotherapy, psychiatric care (medication assessment and monitoring), mental health crisis services, and neuropsychological testing; and HIV dementia coordination. In 1989 AHP was the first agency to promote the concept of specific services for HIV-negative MSM. AHP has furthered its mission of working to decrease the spread of HIV with research, service provision, and an ongoing challenge of doing all that can be done to implement the most rigorously researched interventions toward this goal. AHP has also provided MSM-focused substance use services continuously since 1984, embracing a harm reduction model with services for MSM throughout the process of examining how use affects their lives and HIV risk.

The CPPG will build on the existing HPPC and HSPC structure in SF and will expand to include a broader set of partners

Participant	Designated Position	Letter of Support Signer
Health Department (DPH)	ECHPP Director (New position proposed in ECHPP)	Barbara Garcia: Executive Director, SF DPH
Medicaid Office	Community Programs Director, Marcellina Ogbu, DrPh	Marcellina Ogbu
Mental Health Agency	County Mental Health Director, Jo Robinson	Jo Robinson
Substance Abuse Agency	CBHS Deputy Director for Substance Abuse Services, James Stillwell	James Stillwell
HRSA Ryan White Planning Council	Co-Chairs, SF HIV Health Services Planning Council	Laura Thomas, Lee Jewell: Co-Chairs
HUD/HOPWA Provider Staff	SF Housing and Urban Health Director	Marc Trotz: Director, Housing and Urban Health
CDC Staff	SF HIV Prevention Planning	Frank Strona: Special Projects Coordinator SFDPH - STD Prevention & Control Services
PC and HIV healthcare orgs	SF HIV Health Services Planning Council Provider Representatives	Laura Thomas, Lee Jewell: Co-Chairs
Community-based MH and SU provider	AIDS Health Project HAFC	Laura Thomas, Lee Jewell: Co-Chairs
Individuals most at risk or living with HIV	SF HIV Health Services Planning Council Consumer	Laura Thomas, Lee Jewell: Co-Chairs

	Representatives	
Individuals in recovery from MH/SUD	SF HIV Health Services Planning Council Consumer Representatives	Laura Thomas, Lee Jewell: Co-Chairs

Community members to participate in the BH/PCNC already serve on existing HIV planning groups and were selected because of their HIV experience and expertise. Participating HIV providers were selected to provide services through competitive request for proposals processes. They were required to have at least 2 to 3 years of experience with HIV service provision, and most have 10 or more.

HIV Health Services (HHS) Section CARE Grantee maintains an agreement with Housing and Urban Health (part of DPH Community Programs) to administer CARE funds allocated to housing services. HUH implements and maintains a wide range of housing options for homeless, low-income and disabled people, and awards and monitors contracts funded through CARE and General Funds for housing related services for PLWH/A

Current resources for PLWHA:

Approximately 1,576 PLWH/A receive dedicated housing assistance, and another 1,200 live in other types of publicly subsidized units.

- 635 "Deep" Subsidies cover the difference between 30% of a tenant's income and the market rate of housing unit. Average subsidy: $855 / client / month
- 605 "Shallow" Subsidies provide a flat rental subsidy per month. Average subsidy: $272 /client /month
- 33 Dedicated units in master-leased subsidized supportive housing
- 20 units of HIV Emergency Housing accommodates 200 different people
- 432 Dedicated units in non-profit owned HOPWA-subsidized housing
- 113 Beds in HOPWA-subsidized Residential Care Facilities for the Chronically Ill (RCF-CI)

The San Francisco Department of Public Health (SFDPH) provides supportive housing for homeless persons with serious chronic medical illnesses through its Direct Access to Housing (DAH) program. DAH residents receive permanent housing that includes on-site health care services and/or direct linkage to medical care located near to the DAH units as well as case management and mental health care. DPH Epidemiology conducted a computerized match between the DAH database and the AIDS case registry to identify homeless persons with AIDS who subsequently entered DAH. To assess the impact of housing on health care utilization patterns and costs they compared the change in the mean number of healthcare visits (by type of encounter) or lengths of stay within public hospitals, clinics, and skilled nursing facilities in San Francisco for these individuals in the 24 months before and after receipt of housing. The costs of care were estimated by applying the Medi-Cal reimbursement rate for the type of visit or duration of stay.

A total of 70 homeless persons with AIDS entered DAH between 1996 and 2006 of whom 62 were found to have received care within SFDPH. There were substantial reductions in medical hospital days (71%), skilled nursing facility days (65%), and overall cost of care (57%) after entering DAH. With these declines was a concomitant increase (55%) in medical outpatient visits, mostly primary care. Given that the annual cost per DAH resident is approximately

$10,000-15,000, this shows that permanent supportive housing programs may be effective, cost-effective and even and cost-saving. SF DPH has also applied for additional funding for DAH as part of the Cooperative Agreements Initiative for the Homeless and will ensure coordination through the CPPG.(SF Epidemiology Report 2010)

HOPWA providers are well represented on the CPPG. SFRA will participate in the CPPG and will distribute information to HOPWA grantees. HUH is part of the same division and will be a part of the CPPG. HUH provides annual updates to the CARE Council to ensure collaboration.

The behavioral health network encompasses the City and County of San Francisco, with a particular emphasis on minority communities impacted by higher rates of HIV/AIDS and in need of enhanced behavioral health services.

CPPG activities will include: 1) integrating behavioral health services into the ECHPP, 2) developing and expanding integrated behavioral health and primary care networks with a focus on HIV-related disparities among communities of color, 3) identifying gaps in services/populations reached, 4) identify and promote cross-program collaborations, and 5) developing and maintaining a referral/linkage resource inventory.

The CPPG will include multiple representatives from the target population, including people from the impacted communities, people living with HIV/AIDS, and people with mental illness, substance use disorder, and co-occurring disorders. Members are selected to be representative of the populations served and have full voting rights and privileges of membership.

Screening will be conducted in the CoEs, at Community Clinics, and in the AHP and SHOP sites, according to protocols described in Section B.

The assessment protocol is described above.

Section D: Overall Approach and Staff/Organizational Experience

Through ongoing work with Behavioral Clinicians, SHOP Case Management, and AHP Clinical and Outreach staff, participants will curb risk intensive behaviors and focus their efforts on stability and healthy lifestyles. As a result, 25% of all participants will show improved life skill, indicated by ability to conduct activities of daily living.

Through participation in PCC, Seeking Safety, and other group and individual therapy, 50% of participants will increase health knowledge & health-efficacy, measured through client surveys

Through participation in individual case management and through referrals to Direct Access to Housing and HOPWA opportunities, 50% will have improved conditions of life, measured through housing and health metrics.

As a result of therapeutic interventions directed at the reduction of substance use, 50% of SHOP and AHP clients with SUD will have decreased substance abuse, measured by client survey.

As a result of binge drinking interventions and MI and PCC activities, 50% of AHP clients will have decreased HIV risk behaviors, measured by client survey.

As a result of individual and group interventions, 35% of all clients who initially exhibited risky behavior will have a reduced number of sexual partners, measured by client survey.

Goals	Interventions	Providers	Outcomes
Outreach	Community Based Outreach	AHP COEs	Commencement of Pre-treatment
Case Management Group Therapy Substance Abuse Treatment	PCBHI MI Seeking Safety PCC	COE Behavioral Clinicians SHOP AHP	Improved Life Skills Increase Health Knowledge & Health-Efficacy Improved Conditions of Life Decreased Substance Abuse Link Positive Recovery & Health Behaviors Decreased HIV Risk Behaviors Identification of HIV Status (Some) Entry to HIV Care (Some)
Aftercare Support	SBCM	Behavioral Clinicians SHOP	Recovery from Substance Abuse Maintained Safer Sex Practice Maintained

- **Timeline**

Activities	Completion Date	Responsible Party
Form implementation committee	SAMHSA Notification + 1 week	Deputy Director, Community Programs
Execute collaborative partner MOUs.	SAMHSA Notification + 3 weeks	Deputy Director, Community Programs
Begin Hiring for Community Programs HIV Services Director (CPH)	SAMHSA Notification + 1 month	Deputy Director, Community Programs
Community stakeholder notification	SAMHSA Notification + 1 month	Directors, MNHC, SVN, SHOP, AHP, New
Complete hiring.	SAMHSA Notification + 2 months	Directors, MNHC, SVN, SHOP, AHP
Equip facility, including offices for new staff in primary care area. Furnish space for group activities.	SAMHSA Notification + 2 months	Directors, MNHC, SVN, SHOP, AHP
Establish schedule and template agenda for integrated team operations meetings	SAMHSA Notification + 2 months	Directors, MNHC, SVN, SHOP, AHP
Complete staff training (PC and BH staff)	SAMHSA Notification + 3 months	Staff
Finalize integrated client assessment protocols.	SAMHSA Notification + 3 months	Team

Activities	Completion Date	Responsible Party
Consult with CPPG on final program design and implementation plan.	SAMHSA Notification + 3 months	Director, CPH
Finalize description of clinical services to be provided.	SAMHSA Notification + 3 months	Director, CPH and Clinical Supervisor
Establish data collection instruments and protocols, including database procedures and participant releases.	SAMHSA Notification + 3.5 months	Project Evaluator
Milestone: Implementation Date	SAMHSA Notification + 4 months	
First client assessments completed	Month 1	Behavioral Clinicians, SHOP, AHP
First clients working with Behavioral Health team	Month 1	Team
Milestone: Client satisfaction survey completed	Month 12	
Complete required annual reporting, including analysis of barriers to integration and cultural competency issues	Month 12	Project Evaluator

SF DPH does not foresee any barriers to implementation.

DPH will lead ongoing efforts to leverage funds and resources from multiple sources to ensure the project's long-term success and sustainability, staying abreast of new opportunities. Having created the infrastructure, the services will be sustainable given ongoing or new funding for behavioral health care on the Federal and local levels.

SFDPH: The San Francisco Department of Public Health (SFDPH), Community Behavioral Health Services (CBHS) is the applicant for this grant. CBHS administers the San Francisco Mental Health Plan (SFMHP), which offers mental health benefits to approximately 124,000 San Francisco Medi-Cal (Medicare) beneficiaries, as well as 6,000 Healthy Families members, 9,000 Healthy Workers, 7,000 Healthy Kids, and over 100,000 indigent and uninsured residents of San Francisco. The array of behavioral health programs and services include: outreach and prevention, assessment and placement, outpatient, day treatment, case management, residential, support services, peer and wellness centers, detoxification, medication management, full service partnerships, Prop 36, Drug Court, the Treatment Access Program (TAP), the San Francisco Mental Health Plan (SFMHP), Healthy Workers, Healthy Families/Healthy Kids, Medi-Cal (Short-Doyle, Mental Health, and Drug Medi-Cal), and the Mental Health Services Act.

CBHS is part of the Community Health Programs section of SFDPH, which also houses the Community Oriented Primary Care (COPC) division. COPC includes 12 civil service primary health care centers, six civil service clinics, six civil service youth health centers and clinics, and ten affiliated non-profit primary and specialty care clinics.

CBHS has a long history of internal collaboration with other DPH sections, including the HIV Health Services and HIV Prevention Sections. This collaboration enhances The SFDPH's

capacity to ensure that all services and efforts related to HIV are in line with the National HIV/AIDS Strategy and local priorities and plans, including ECHPP.

HAFC: The SHOP program is run by Walden House, one of the two merging partners in HAFC. Walden House is a 501(c)3 non-profit providing a wide spectrum of behavioral health services to indigent and criminal justice involved individuals in California since 1969. They have provided residential substance abuse treatment and related services to adults in San Francisco for over 40 years. Residential services targeted specifically for people with HIV/AIDS have been part of the WH continuum since 1989. WH has been a certified provider of Medi-Cal billable mental health services since 1996. Within our system of care, a wide range of behavioral health and ancillary services are available to address participants' needs related to drivers, cofactors, and other behavioral risks and contexts for HIV infection or transmission.

HAFC's long history of growth through innovation and adaptation to match emerging population needs with promising and evidence based practices, and collaboration with our partners and funders to ensure that services are responsive to and effective for all stakeholders, are evidence of their stability, experience, and expertise in serving San Francisco's underserved and high risk populations.

AHP: Since 1984, AHP has used the epidemiology of the HIV epidemic in SF along with the guidance of SFDPH to target its HIV prevention services. Serving more than 8,000 clients annually, AHP offers a full spectrum of behavioral health services from its 15,000 square foot Client Services facility located at 1930 Market Street and through its community and mobile services. The services provided include HIV/STI counseling and testing; substance use counseling/case management; individual and group risk-reduction counseling; individual and group psychotherapy, psychiatric care (medication assessment and monitoring), mental health crisis services, and neuropsychological testing; and HIV dementia coordination. AHP provides more than 80 hours of psychotherapy each week, nearly 25 support groups ranging from groups for HIV-positive people and people with AIDS, to more focused groups for gay and bisexual men who recently moved to San Francisco, Queer-identified Women with Disabilities and a Transgender Mental Health group.

Each of the service organizations (culturally specific CoEs, AIDS Health Project, SHOP/HAFC, Mission Mental Health, South Van Ness Mental Health) has been intentionally developed over the years to have deep connections to a particular community. The success of each over the years has been based on the ability to draw from both the community risk pool and the community concern/advocacy pool. Each of these programs has been chosen by RFP for its design and history of reaching the specified risk population.

Quarterly in-service trainings are provided to clinical staff on some aspect of cultural competence and the agencies, through their annual Cultural Competence Reports submitted to SF DPH, develop annual goals and objectives targeting cultural competence.

Position/Role	LOE
San Francisco Department of Public Health	
Evaluation Director	.20
Project Evaluator	1.0
Community Programs Director of HIV Services (Project Director)	1.0
Clinical Supervisor (Psychologist)	0.33
Behavioral Clinician	4.7
Data Analyst	1.0
Haight Ashbury Free Clinics (HAFC) SHOP	
Program Manager	.10
TMH Manager	.05
Substance Abuse/Case Managers	2.0
Peer Outreach	2.0
UCSF AIDS Health Project (AHP)	
Team Psychiatrist	.04
Program Director	.20
Clinical Social Worker	.33
Substance Abuse Counselor	.66
Receptionist	.25

AHP

Psychiatrist, George Harrison, M.D., 4% time. Dr. Harrison will serve as psychiatrist for the project. Dr. Harrison is a board-certified psychiatrist with a specialty in HIV and LGBTQ issues. Dr. Harrison is the Medical Director of UCSF AIDS Health Project. For the proposed project, his duties will include psychiatric assessment, medication management and clinical consultation.

Program Director, Ramón Matos, MFT, 20% time. Mr. Matos will provide oversight and leadership to all aspect of this program. Mr. Matos has nineteen years experience developing, managing, and improving social service programs. He is trained and experienced in utilizing Motivational Interviewing. He is also trained in conducting the PCC intervention. Mr. Matos is bicultural Latino/Anglo and bilingual Spanish/English.

The resources available to the proposed project are numerous. The project: 1) will utilize existing accessible and ADA-compliant facilities well-known to the community and to the target population; 2) build on past experience working with the target population; and 3) include in-kind staff experienced in providing services to the target population in an integrated services environment.

SFDPH can support the programs in this project with resources from other departments of the agency, such as the AIDS Office and STD Unit. In addition to the HIV rapid testing, participants in the program will be able to receive STD testing at other SFDPH-funded programs in the community. The Urgent Care Unit will be available for to address the immediate health needs of

clients who are not enrolled into a physician's caseload. The AIDS Office will be able to provide additional resources for those who want to test during the outreach phase of the program.

Section E: Performance Assessment and Data

SFDPH has extensive experience in collecting, managing, analyzing and reporting NOMS and GPRA data into the web-based data entry and reporting system for over 11 SAMHSA CMHS and CSAT grants, achieving the required 80% retention over multiple waves of data collection. We have a proven track record in effectively collecting, managing, and utilizing this data for outcome assessment and quality improvement.

SFDPH will comply with electronic/web-based submission of performance data at baseline, discharge, and 6 months post baseline. CBHS will have clinical and program staff consent participants into MAI. As part of the client intake at the Center of Excellence, mental health clinic, or substance abuse treatment program, the NOMS will be administered in a confidential setting. The NOMS will be given to a member of the Evaluation team for data entry into the TRAC system. All of the required outcome data can be extracted from the TRAC, by system by accessing the NOMS data. As client participation in a CBHS program, Evaluation staff will also have access to Billing Information System (BIS), AVATAR data (Electronic Health Records for CBHS clinics and programs) and the Coordinated Case Management System (CCMS), which functions as an integrated electronic charting, reporting, and communication tool for teams working with clients who are served across multiple systems of care in San Francisco. CCMS pulls data from twenty databases (including DPH's Lifetime Clinical Record and the (BIS) and data systems in five city departments and integrates them into one electronic medical record.

SFDPH will use data from the NOMS, BIS, AVATAR, and CCMS to provide a summary of clients' contacts with all SFDPH funded health, mental health and substance abuse episodes. The CCMS information includes: type of treatment facility, drug use patterns, dates, number of treatment contacts, and legal status. Client demographic information, and outcome information for drug use, HIV risk behaviors, mental health, physical health, legal problems, financial problems, housing, and family/social relationships is collected by case managers at baseline and Evaluation staff at follow-up. CCMS data allows tracking of services provided, the service provider(s) (e.g., modality, agency), and the context in which services were provided. Individual demographic, substance use, and other information from the CCMS can be "cross-referenced" with service utilization, treatment retention, and overall progress in treatment to determine if these individual factors appear to impact outcomes.

The evaluation plan includes data collection, management, analysis, and required reporting, as well as the use of tools to assess the project's impact. The process evaluation will study the configuration, implementation, and performance aspects of the project, while outcome evaluation will focus on stated outcome measures. The evaluation will draw from numerous sources, including Duke Health Profile, NOMS/GPRA, the Department of Public Health's Billing Information System and the CCMS system, Data will be exported to a central project database. Evaluators will document project implementation and design fidelity, and identify barriers early during implementation in order to drive any needed modifications.

Program Outcomes:

1. 50% of all participants will show improved life skill, indicated by ability to conduct activities of daily living as clients will keep clinical appointment dates, measured by case management records
2. 50% will have improved conditions of life, measured by the NOMS/GPRA
3. 50% of participants in enrolled in clinical or treatment services will have decreased substance abuse, measured by NOMS/GPRA
4. 50% of AHP clients will have decreased HIV risk behaviors, measured by case management records
5. 35% of all clients enrolled in clinical or treatment services will have reduced number of sexual partners, measured by GPRA/NOMS
6. 100% of clients will participate in at least one additional service through San Francisco Minority AIDS Initiative, measured by case management records..
7. Each project year, a minimum of 60% of clients enrolled in clinical or treatment services with trauma symptoms will show decreased symptoms of trauma as measured on the *Trauma Symptom Checklist*
8. Each project year, by engaging in PC/BH services (at least two interactions per month).a minimum of 60% of clients will show a reduction in adverse behavioral health risk factors, measured by NOMS/GPRA and case management records
9. Each project year, by successfully working with a Behaviorist Clinicians (at least two interactions per month) a minimum of 60% of clients will reduce HIV risk and incidence as measured by GPRA/NOMS, moving them one step closer to health wellness and recovery.

Project findings will be reviewed by key staff and presented to the participating programs at regular intervals, particularly at the monthly BH/PCNC stakeholder meetings. Anticipated and unanticipated trends or outcomes, as well as progress in meeting programmatic goals will be reviewed and discussed. This process will highlight aspects of the program that are working well, and identify areas that may need modifications to maximize effectiveness for the target population. Ongoing programmatic evaluation and information sharing is particularly important when a program is new, involves multiple components, provides innovative services, and targets a complex set of issues. This has been the established practice for other SAMHSA funded projects, and has contributed significantly to the success of these programs. The evaluation will also serve to ensure fidelity to the program. CBHS Evaluation will report on infrastructure changes made throughout the grant project period as they are implemented, including program implementation, upgrades to CCMS, the electronic medical records program, and E-Referral systems, development of new practice guidelines and tools, and workforce development activities (primarily, core competency training for new staff). Peer recovery staff and consumers participate in the stakeholder meeting, will work in the program, thus will be able to review program trends, particularly as they relate to serving communities of color.

Monthly meetings will be held with BH/PCNC stakeholder group, managerial staff, key program staff, including peers and consumers, to discuss project and evaluation progress and SAMHSA requirements. At this monthly meeting, the data outcomes will be reviewed in aggregate form, but analyzed and presented to track reduction of the impact of behavioral health problems, HIV risk and incidence, and HIV related health disparities. The Project Evaluator will review the

project/research questions, report on the data sources used for the analysis, discuss the analysis plan, and report on project and research findings. The Evaluator will be able to document feedback from program staff and incorporate this information in the process evaluation. At the monthly meeting 30 days prior to the submission of the bi-annual report, the Evaluator will present a draft of the report and solicit feedback and edits. The structure of the BH/PCNC stakeholder group, within the monthly meeting format, will enable the Evaluation team to not only present process and outcome data, but also outline the content for the bi-annual reports, with stakeholder review and feedback. Staff at CBHS has experience in summarizing an interpreting drug use data from a variety of sources including NOMS/GPRA and CCMS data as well as preparing bi-annual and final written reports to CSAT/SAMHSA. The San Francisco MAI, with CBHS Evaluation, will prepare and submit bi-annual reports to during the project.

National Outcome Measures (NOMS)/Government Performance and Results Act (GPRA)

The National Outcome Measures (NOMs) system—developed jointly by SAMHSA, the states, and the District of Columbia—tracks and measures real-life outcomes for people in recovery from mental health and substance abuse disorders

Trauma Symptom Checklist (TSC-40)

The TSC-40 is a 40 item self-report measure of symptoms associated with exposure to trauma. There is a total score as well as six subscale scores including: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index (SATI), Sexual Problems, and Sleep Disturbance. Reliability estimates range from .89 to .91 for the full scale, and from .66 to .77 for the subscales.

Evaluation Plan

The proposed evaluation will use a quasi-experimental design with both process and outcome evaluation methodologies and be implemented as a collaboration and partnership between CBHS Research and Evaluation staff, Behavioral Clinicians from CBHS assigned to the Centers of Excellence, and Behavioral Health Providers- Walden House and AIDS Health Project. Process evaluation data will consist of clinician and provider intake, discharge, client satisfaction and service utilization forms. The intake/discharge forms will capture basic demographics information and discharge reasons, while frequency and usage of core service components will be tracked using Behavioral Clinicians' group, attendance and other tracking forms. All process evaluation data will be entered by CBHS Evaluation staff into the Project Evaluation data system. A referral and tracking form will be created by CBHS Evaluation staff to track clients engaged and recruited into services at each site.

CBHS Evaluation staff will conduct all outcome assessments with the clients engaged into the program. The NOMS/GPRA will be administered by treatment staff at intake and discharge and 6 months post baseline follow-up will be completed by Evaluation staff. Completed NOMS/GPRA instruments will be given to the CBHS Evaluation staff for data entry into CSAT's web-based GPRA Data Entry and Reporting system within 7 business days of completion. Additionally, the CBHS Evaluator will also conduct regular checks of the GPRA website, with follow-up rates reported during weekly MAI staff meetings. Completed local evaluation measures will be entered into a TRAC database developed by the evaluation team. The CBHS Evaluator will be responsible for ensuring that both the NOMS/GPRA and local

evaluation measures data entry is accurate. Biannual data checks of the local evaluation data will also occur.

The Trauma Symptom Index will be self administered by clients at baseline, 6-month post baseline, and discharge. This will provide data points that are concurrent with the NOMS/GPRA data collection time line, providing outcome indicators for evaluation.

The Evaluation staff will work in collaboration with clinical and program staff to identify clients when they enter the appropriate time window for the assessments. The names of these clients will then be communicated and assigned to Evaluation staff during weekly staff meetings. Methods for locating clients, beyond phone/mail contact, may include contact with identified peer networks (listed on locator forms), other service providers or social services. No cash incentives will be offered for completion of baseline instruments. However, clients will receive a $20 gift card from the Evaluation staff for each completed follow-up assessments.

For the process evaluation, Evaluation staff will conduct annual interviews with all key clinical staff as well as administer satisfaction surveys with program staff. Furthermore, annually approximately 20% of the participants will be individually interviewed regarding the program efficacy. CBHS Research and Evaluation will work collaboratively to ensure that the project will be in compliance with CBHS and SAMHSA standards and expectation for program implementation, data collection, and outcome analysis.

Data Analysis

Statistical tests that will be used to evaluate the effectiveness of achieving program goals and objectives may include, but are not limited to, paired t-tests, chi-square, and univariate and multivariate statistics (ANOVA, multiple regression, repeated measures, etc.). All analyses will be performed using SAS software for Windows 95, SAS Institute, North Carolina, Version 9.1.

Regression analysis would be utilized to determine effects on the dependent variables with any potential confounds added as covariates in order to determine outcome effects. The analysis will provide information on significance differences in outcome scores, with comparison between each measurement point and an aggregation of data from previous measurement points.

The evaluation team will work collaboratively with program administrators and staff to complete regular and bi-annual SAMHSA progress reports, as well as the final evaluation report. NOMS/GPRA follow-up rates are already automatically tracked by SAMHSA and will be presented at weekly staff meetings by the project administrative assistant. Preliminary data analysis findings will be presented to project administrators/staff and other key stakeholders biannually; at minimum (see Section E-4 above). Written summaries will be submitted with SAMHSA progress reports.

Preliminary data analysis will be conducted by the evaluation team biannually at minimum and as data becomes available. This may include client demographics, service usage/tracking data, and/or a snapshot of outcome data available to date. NOMS/GPRA and local evaluation data may also be used to identify client issues related to substance use, psychiatric symptoms, criminal justice, social factors, and primary care conditions.

Total annual grant of $1,500,000, minus 10% for evaluation, leaves $1,350,000 for services and infrastructure. $1,350,000 divided by the 375 annual unduplicated clients is $3,600 per unduplicated client.

1. DATE ISSUED (Mo./Day/Yr.) 09/28/2011 | 2. CFDA NO. 93.243

3. SUPERSEDES AWARD NOTICE dated 09/13/2011 except that any additions or restrictions previously imposed remain in effect unless specifically rescinded.

4. GRANT NO. 6 U79 SM060706-01-1
Formerly:

5. ADMINISTRATIVE CODES
SM-U79/MAI-TCE

6. PROJECT PERIOD Mo./Day/Yr. — Mo./Day/Yr.
From 09/30/2011 Through 09/29/2014

7. BUDGET PERIOD Mo./Day/Yr. — Mo./Day/Yr.
From 09/30/2011 Through 09/29/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

REVISED

COPY

NOTICE OF GRANT AWARD

AUTHORIZATION (Legislation/Regulation)
under Section 509, 516, and 520 of the PHS Act as amended

8. TITLE OF PROJECT (OR PROGRAM) (Limit to 56 spaces)
San Francisco Minority AIDS Initiative

9. GRANTEE NAME AND ADDRESS
a. SAN FRANCISCO DEPT OF PUBLIC HEALTH
b.
c. 1380 Howard Street, 5th Fl
d. San Francisco e. CA f. 94103-2651

10. DIRECTOR OF PROJECT (PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR) (LAST NAME FIRST AND ADDRESS)
Rucker, Toni
San Francisco Dept. of Public Health
1380 Howard Street
San Francisco, CA 94803

11. APPROVED BUDGET (Excludes PHS Direct Assistance)

I PHS Grant Funds Only
II Total project costs including grant funds and all other financial participation
(Select one and place NUMERAL in box.) [ ]

a. Salaries and Wages	$	673,065
b. Fringe Benefits	$	289,418
c. Total Personnel Costs	$	962,483
d. Consultant Costs		0
e. Equipment		0
f. Supplies		13,000
g. Travel		3,965
h. Patient Care - Inpatient		0
i. - Outpatient		0
j. Alterations and Renovations		0
k. Other		94,021
l. Consortium/Contractual Costs		278,672
m. Trainee Related Expenses		0
n. Trainee Stipends		0
o. Trainee Tuition and Fees		0
p. Trainee Travel		0
q. TOTAL DIRECT COSTS →	$	1,352,141
r. INDIRECT COSTS (Rate .00 % of S&W/TADC)	$	0
s. TOTAL APPROVED BUDGET	$	1,352,141
t. SBIR Fee	$	
u. Federal Share	$	1,352,141
v. Non-Federal Share	$	0

12. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE

a. Amount of PHS Financial Assistance (from item 11u)	$	1,352,141
b. Less Unobligated Balance From Prior Budget Periods	$	0
c. Less Cumulative Prior Award(s) This Budget Period	$	1,328,657
d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	$	$23,484

13. RECOMMENDED FUTURE SUPPORT (SUBJECT TO THE AVAILABILITY OF FUNDS AND SATISFACTORY PROGRESS OF THE PROJECT)

YEAR	TOTAL COSTS (DIRECT and INDIRECT)	YEAR	TOTAL COSTS (DIRECT and INDIRECT)
a. 02	1,328,657	d.	
b. 03	1,328,657	e.	
c.	N/A	f.	

14. APPROVED DIRECT ASSISTANCE BUDGET (IN LIEU OF CASH):

a. Amount of PHS Direct Assistance	$	
b. Less Unobligated Balance From Prior Budget Periods	$	
c. Less Cumulative Prior Award(s) This Budget Period	$	
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	$	N/A

15. PROGRAM INCOME SUBJECT TO 45 CFR PART 74, SUBPART F, OR 45 CFR 92.25, SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES: (Select One and Place LETTER in box.)

a. DEDUCTION
b. ADDITIONAL COSTS
c. MATCHING
d. OTHER RESEARCH (Add/Deduct Option) [B]
e. OTHER (See REMARKS)

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, THE PHS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:

a. The grant program legislation cited above, b. The grant program regulation cited above,
c. The award notice including terms and conditions, if any, noted below under REMARKS.
d. PHS Grants Policy Statement including addenda in effect as of the beginning date of the budget period.
e. 45 CFR Part 74 or 45 CFR Part 92 as applicable,

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS: (Other Terms and Conditions Attached - [ ] Yes [ ] No)

GMS: Fairfax, Sherie (240)276-1415 PO: Ruditis, Ilze L (240)276-1961

PHS GRANTS MANAGEMENT OFFICER: (Signature) (Name-Typed/Print) Simpson, Gwendolyn (Title) Grants Management Officer, SAMHSA, Acti

17. OBJ. CLASS. 41.45 | 18. CRS - EIN 1946000417A8 | 19. LIST NO:

	FYCAN	DOCUMENT NO.	ADMINISTRATIVE CODE	AMT. ACTION FIN. ASST.	AMT. ACTION DIR. ASST.
20.a.	2011C96C523	b. 11SM60706A	c.	d. $1,115	e.
21.a	2011C96P115	b. 11SM60706A	c.	d. $22,369	e.
22.a.		b.	c.	d.	e.

PHS-5152-3 (REV. 7/92)

(Note: See reverse for payment information.)

File No. 120089

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s): Members, SF Board of Supervisors	City elective office(s) held: Members, SF Board of Supervisors

Contractor Information *(Please print clearly.)*	
Name of contractor: **Haight Ashbury Free Clinics-Walden House**	
Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary. (1) Stephen Bach, Deborah Broyles, Todd Choy, Susan Christian, Tom Christian, Eric Flowers, Dianne Fong-Torres, Judge Harlan Grossman, Graham Gunst, Tamara Mason-Williams, Victor Ortiz, Peter Sullivan, Jeanne Woodford, Yanie Chaumette, Liam Mayclem, Louise McGinnis-Barber, Marguerite Meade, David Crawford, Dr. Vitka Eisen; (2) the Chief Executive Officer is Dr. Vitka Eisen, and the Chief Financial Officer is David Crawford; (3) None; (4) None; and (5) None	
Contractor address: Administrative Office: 1735 Mission Street, San Francisco, CA 94103 Phone 415-746-1967	
Date that contract was approved:	Amount of contract: $253,043 over 3 years
Describe the nature of the contract that was approved: The SHOP/Walden House Expansion will build on a proven practice for engaging clients in the Southeast section of San Francisco, where clients are often reluctant to engage in services. By providing San Francisco Minority AIDS Initiative additional outreach, case management, clinical interventions, and substance abuse counseling, SHOP will further decrease the spread of infections in the Bayview Hunters Point and surrounding neighborhoods.	
Comments:	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form (Mayor Edwin M. Lee)

☐ a board on which the City elective officer(s) serves San Francisco Board of Supervisors
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____
Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer: Angela Calvillo, Clerk of the SF Board of Supervisors	Contact telephone number: (415) 554-5184
Address: City Hall, Room 244 1 Dr. Carlton B. Goodlett Place	E-mail: Board.of.Supervisors@sfgov.org

_____ _____
Signature of City Elective Officer (if submitted by City elective officer) Date Signed

_____ _____
Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed