

File No. 130942

Committee Item No. 6

Board Item No. _____

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget and Finance Committee

Date: 10/09/2013

Board of Supervisors Meeting

Date: _____

Cmte Board

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| <input type="checkbox"/> | <input type="checkbox"/> | Youth Commission Report |
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Completed by: Victor Young Date October 4, 2013

Completed by: Victor Young Date _____

1 [Approval of the Ryan White Act HIV/AIDS Emergency Relief Grant Program Application -
2 \$36,118,233]

3 **Resolution authorizing the Department of Public Health to submit an application to**
4 **continue to receive funding for the Ryan White Act HIV/AIDS Emergency Relief Grant**
5 **Program (Ryan White Programs, Part A) grant from the Health Resources Services**
6 **Administration, requesting \$36,118,233 in HIV emergency relief program funding for the**
7 **San Francisco Eligible Metropolitan Area for the period of March 1, 2014, through**
8 **February 28, 2015.**

9
10 WHEREAS, Section 10.170.(b) of the San Francisco Administrative Code requires
11 Board review of proposed annual or otherwise recurring grant applications of \$5,000,000 or
12 more prior to their submission; and

13 WHEREAS, San Francisco Department of Public Health (SFDPH) is currently a
14 recipient of the "Ryan White Act HIV/AIDS Emergency Relief Grant Program" grant in the
15 amount of approximately \$36,118,233 from the Health Resources Services Administration
16 (HRSA) for fiscal year 2013; and

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

19 WHEREAS, SFDPH uses these funds to cover a multitude of health services to HIV
20 positive persons residing in the three counties within the San Francisco Eligible Metropolitan
21 Areas; and


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

24 WHEREAS, HRSA released the application announcement on August 12, 2013, with a
25 due date of October 09, 2013, allowing 58 days for the entire process; and

1 WHEREAS, in the interest of timeliness, SFDPH is making this request for approval by
2 submitting its' most recent draft of the grant application, also including supporting documents
3 as required, all of which are on file with the Clerk of the Board of Supervisors in File No.
4 130942, which is hereby declared to be part of the Resolution as if set forth
5 fully herein; and, now, therefore, be it

6 RESOLVED, That the Board of Supervisors hereby approves SFDPH's application
7 submission to HRSA for the "Ryan White Act HIV/AIDS Emergency Relief Grant Program
8 (Ryan White Programs, Part A)" grant for the funding period of March 1, 2014 through
9 February 28, 2015, to be submitted no later than October 09, 2013.

10
11 RECOMMENDED:

12
13 
14 _____

15 Barbara A. Garcia, MPA
16 Director of Health



Edwin M. Lee
Mayor

TO: Jason Elliott, Director of Legislative & Government Affairs
Jermain Jones, Legislative Aide

FROM: Richelle-Lynn Mojica, Grants Manager

DATE: September 14, 2013

SUBJECT: Resolution authorizing the San Francisco Department of Public Health to apply for the Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A) grant

GRANT TITLE: HIV Emergency Relief Grant Program (Ryan White Programs, Part A)- \$36,118,233

Enclosed, please find the original and 4 copies of the HIV Emergency Relief Grant Program (Ryan White Programs, Part A) Grant Application- \$36,118,233. This is per Section 10.170.(b) of the San Francisco Administrative Code which requires Board review of proposed annual or otherwise recurring grant applications of \$5,000,000 or more prior to their submission.

Should you have any questions, please contact me at Richelle-Lynn.Mojica@sfdph.org or at 415-255-3555.

Thank you.



Barbara Garcia
Director of Health

September 3, 2013

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

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

Dear Ms. Cavillo:

Attached please find an original and four copies of a proposed resolution for the approval of the Board of Supervisors, which authorizes the San Francisco Department of Public Health (SFDPH) to submit an application for the Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A) to the Health Resources Services Administration (HRSA). This application is required to receive continued funding for the period of March 1, 2014 to February 28, 2015. This application represents approximately \$36,118,233 in funding for the San Francisco Eligible Metropolitan Area (EMA). The San Francisco EMA includes the City and County of San Francisco, Marin County and San Mateo County. The funding supports a multitude of health services to HIV positive persons residing in these three counties.

This resolution is required by Ordinance No. 265-05, which amends Section 10-170 of the Administrative Code to require Board of Supervisors review of recurring grant applications of \$5,000,000 or more prior to their submission. SFDPH received from HRSA the application guidance on August 12, 2013. The application deadline is October 9, 2013.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Barbara Garcia", with a small "for" written below it.

Barbara Garcia
Director of Health

Enclosures

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



Barbara Garcia
Director of Health

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

Funding Criteria

The San Francisco Department of Public Health (SFDPH) is currently a recipient of the Ryan White HIV/AIDS HIV Emergency Relief Grant Program (Ryan White Programs, Part A) in the amount of \$17,925,024 from the Health Resources Services Administration (HRSA). The Part A grant is awarded to the San Francisco Eligible Metropolitan Area which is comprised of the City and County of San Francisco, Marin County, and San Mateo County.

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

Department's Most Recent Draft of Grant Applications Materials

Please see Attachment A for the SFDPH's most recent draft of application materials. SFDPH's most recent application was submitted to HRSA on Oct 22, 2012 for the funding period of March 1, 2013 to February 28, 2014. We have received the application guidance from HRSA for the March 1, 2014 to February 28, 2015 funding period on August 12, 2013 with an application due date of October 09, 2013.

Anticipated Funding Categories

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

Comments from Relevant Citizen Advisory Board

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

SF HHSPC
 Planning Council Roster
 Attachment B

Name	Affiliation	End of Term
1. Margot Antonetty	SFDPH- HUH	1/31/2014
2. Margaret Baran	IHSS Consortium- LTCCC	7/29/2014
3. Billie Cooper		10/01/2013
4. Brian DiCrocco		1/30/2014
5. Cicily Emerson	Marin Dept. of Health & Human Services	6/27/2015
6. Wade Flores		10/30/2013
7. Liz Gatewood	SFDPH- Medical Respite	3/31/2014
8. Matt Geltmaker	San Mateo County Health Department	6/13/2015
9. Ron Hernandez		5/20/2014
10. Mary Lawrence Hicks	UCSF	9/03/2014
11. Kenneth Hornby		9/25/2013
12. Carol Hudson		6/13/2015
13. Bruce Ito	Mayor's Office of Housing	9/24/2014
14. Lee Jewell		12/30/13
15. William Ledford		2/25/2015
16. Mayra Lopez	Mission Neighborhood Health Center	2/25/2015
17. Rachel Matillano		6/27/2015
18. Matthew Miller		3/28/2015
19. Catherine Newell		4/30/2014
20. Gabriel Ortega		5/20/2014
21. Ken Pearce		8/31/2013
22. Maritza Penagos	AIDS Emergency Fund	12/2/2014
23. Michael Scarce		1/24/2014
24. Stacia Scherich		6/13/2015
25. Charles Siron		2/28/2014
26. Gwen Smith	SFDPH- Southeast Health Center	1/31/2014
27. Michael Smithwick	Maitri	3/25/2014
28. Don Soto	Lutheran Social Services of Northern California	8/31/2013
29. Chip Supanich	Shanti	1/25/2015
30. Eric Sutter	Shanti	3/31/2014
31. Laura Thomas	Drug Policy Alliance	2/28/2014
32. Channing Wayne	Larkin Street Youth Services	4/27/2014

FY 2013 PROJECT ABSTRACT

Project Title: Preparing for Change: San Francisco EMA FY 2013 Ryan White Part A Competing Continuation Application Narrative

Applicant Name: San Francisco HIV Health Services, Bill Blum, Interim Director

HRSA Grant #: H89HA00006

Address: 25 Van Ness Avenue, Suite 500, San Francisco, CA, 94102

Contact Phone #: Office: (415) 554-9105 / Fax: (415) 431-7547

E-Mail Address: bill.blum@sfdph.org / **Web Address:** www.sfhivcare.com

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

As of December 31, 2011, a total of **33,099** cumulative AIDS cases had been diagnosed in the EMA, with over **22,384** persons having died of AIDS. A total of **11,587** persons were living with AIDS in the San Francisco EMA as of December 31, 2011 with roughly the same number estimated to be living with HIV, for a total of at least **23,156** persons living with HIV in the three-county region. This means that more than **1 in every 77 residents of the San Francisco EMA is infected and living with HIV**. At the epicenter of this crisis is the city and county of San Francisco, which continues to have the nation's **highest per capita prevalence of cumulative AIDS cases**.

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

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

**PREPARING FOR CHANGE:
SAN FRANCISCO EMA FY 2013 RYAN WHITE PART A
COMPETING CONTINUATION APPLICATION NARRATIVE
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**PREPARING FOR CHANGE:
SAN FRANCISCO EMA FY 2012 RYAN WHITE PART A
COMPETING CONTINUATION APPLICATION NARRATIVE**

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

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

1. DEMONSTRATED NEED

Introduction to the San Francisco EMA

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

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

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

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

1.a) HIV/AIDS Epidemiology

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

See Table in Attachment 3

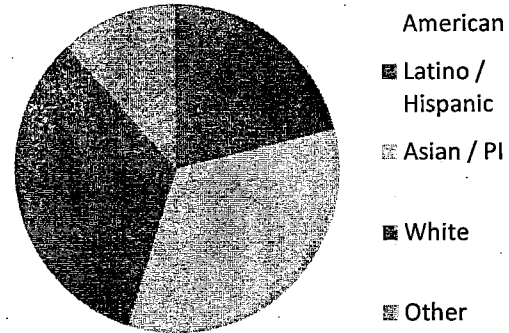
1.a.2) HIV/AIDS Epidemiology

Narrative

Description of Current HIV/AIDS Cases: More than a quarter century into the HIV epidemic, the three counties of the San Francisco EMA continue to be devastated by HIV – an ongoing crisis that has exacted an enormous human and financial toll on our region. According to the State of California, as of December 31, 2011, a total of **33,099** cumulative AIDS cases had been diagnosed in the EMA, representing more than **one in five** of all AIDS cases ever diagnosed in the state of California (n=161,847).³ Over **22,384** persons have already died as a result of HIV infection in the EMA. As of December 31, 2011, a total of **11,587** persons were living with AIDS in the EMA's three counties while at least the same number were believed to be living with HIV, for an estimated total of at least **23,156** persons living with HIV infection in the three-county region (see Table in Attachment 3).⁴ This represents an EMA-wide HIV infection incidence of **1,303.8** cases per 100,000 persons, meaning that approximately **1 in every 77 residents of the San Francisco EMA is now living with HIV**. A total of **1,118** new cases of AIDS were diagnosed in the EMA over the three-year period between January 1, 2009 and December 31, 2011 alone, representing **9.7%** of all persons living with AIDS as of that date.

At the epicenter of this continuing crisis lies the City and County of San Francisco, the city hardest-hit during the initial years of the AIDS epidemic. **Today, the City of San Francisco continues to have the nation's highest per capita prevalence of cumulative AIDS cases,⁵ and HIV/AIDS remains the leading cause of death in the city among all age groups, as it has been for nearly two decades.⁶** The number of persons living with AIDS in San Francisco has increased by nearly **20%** over the last decade alone - a percentage that does include more rapidly escalating non-AIDS HIV cases. Through December 31, 2011, a cumulative total of **29,073** cases of AIDS have been diagnosed in San Francisco, accounting for nearly **3%** of all AIDS cases ever identified in the US as of the end of 2010 (n=1,106,499) and nearly **20%** of all AIDS cases diagnosed in California (n=161,847), despite the fact that San Francisco County contains only **2%** of the state's population.⁷ As of the end of 2011, an estimated **19,830** San Franciscans were living with AIDS or HIV, representing **85.6 %** of all persons living with HIV/AIDS in the EMA, for a staggering citywide prevalence of **2,462.6** cases of HIV per 100,000. **This means that**

Figure 1. Ethnic Distribution of San Francisco Residents, 2010 Census



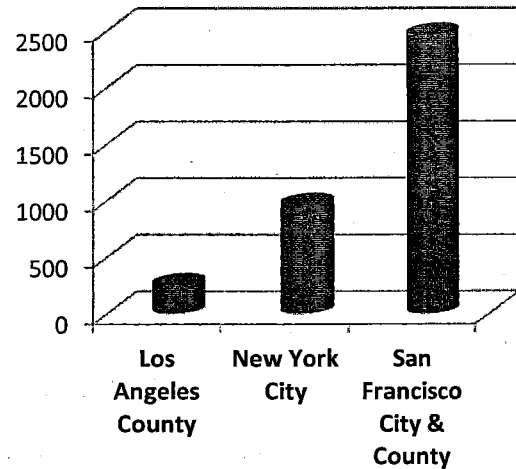
nearly 1 in every 41 San Francisco residents is now living with HIV disease - an astonishing concentration of HIV infection in a city with a population of just over 800,000. As of December 2011, the incidence of persons living with AIDS per 100,000 in San Francisco County was over **nearly ten times** that of Los Angeles County (**251.8** per 100,000) and **nearly three times** that of New York City (**960.3** per 100,000) (see Figure 1).⁸ The following sections provide information on the specific demographics of the local HIV epidemic.

Race / Ethnicity: Reflecting the ethnic diversity of our EMA, the region's HIV/AIDS caseload is distributed among a wide range of ethnic groups. The majority of persons living with HIV and AIDS in the EMA are white (**61.4%**), while **13.5%** of cases are among African

Americans; **17.4%** are among Latinos; and **5.3%** are among Asian / Pacific Islanders. A total of **4,532** persons of color were living with AIDS in the San Francisco EMA as of December 31, 2011, representing **39.1 %** of all PLWA, while another **4,411** persons of color were estimated to be living with HIV as of the same date (**38.1%** of all PLWHA), for a total of **8,943** persons of color living with HIV/AIDS. **However, the percentage of new AIDS cases among persons of color is increasing rapidly, particularly within Latino and Asian / Pacific Islander communities.** While 39.1% of all people living with AIDS as of December 31, 2011 were persons of color, **over half (50.6%)** of new AIDS cases diagnosed between January 1, 2009 and December 31, 2011 were among persons of color (n=566). **This represents the first three-year period in the EMA's history in which persons of color made up the majority of those newly diagnosed with AIDS.** Latinos grew from **15.5%** to **17.4%** of all PLWHA living in the EMA between 12/31/08 and 12/31/11, while Asian / Pacific Islanders increased from **4.8%** to **5.3%** of cases over the same period. Additionally among the EMA's hard-hit transgender population, persons of color make up **78.7%** of all PLWHA, including a population that is **34.7%** African American, **31.3%** Latino, and **9.7%** Asian / Pacific Islander.

Transmission Categories: The most important distinguishing characteristic of the HIV epidemic in the San Francisco EMA involves the fact that HIV remains primarily a disease of men who have sex with men (MSM). In other regions of the US, the proportionate impact of HIV on MSM has declined over time as other populations such as women, injection drug users, and heterosexual men have been increasingly affected by the epidemic. While these groups have been impacted in our region as well, their representation as a proportion of total persons living with HIV and AIDS (PLWHA) has not been nearly as high. Through December 31, 2011, fully **85.4%** of persons living with HIV/AIDS in our region were MSM (**19,784**), including **16,602** men infected with HIV through MSM contact only (**71.7%** of all PLWHA) and **3,182** MSM who also injected drugs (**13.7%** of all PLWHA). This represents an **increase** from the end of 2008, when MSM made up **82.3%** of all PLWHA. By comparison, only **34.1%** of PLWHA in New York City as of December 31, 2010 were listed as infected through MSM contact.⁹ Factors underlying this difference include the high proportion of gay and bisexual men living in the

Figure 2. Persons Living with AIDS Per 100,000 Population - Selected Metropolitan Areas



EMA and the large number of long-term HIV survivors in the region. Other significant local transmission categories include heterosexual injection drug users (6.9% of PLWHA) and non-IDU heterosexuals (3.9%). There are signs that both populations may be increasing, however, with 6.4% of new AIDS cases between 2008 and 2010 occurring among non-drug-using heterosexuals (n=72) and 9.5% occurring among non-MSM injection drug users.

Gender: Reflecting the high prevalence of HIV/AIDS among men who have sex with men, the vast majority of those living with HIV and AIDS in the San Francisco EMA (91.3%) are men. 6.5% of all PLWHA in the region are women, 70.0% of whom are women of color. Among African Americans living with HIV/AIDS, 15.2% are women. **The San Francisco EMA contains what is by far the lowest percentage of women, infants, children, and youth (WICY) living with HIV/AIDS through 2008 of any EMA or TGA in the nation, with WICY populations making up only 7.95% of PLWHA** (see Figure 3). In the city of San Francisco, the percentage is even lower, at 5.8% of cases (n=500). By comparison, the next highest EMA - Denver, CO - has a WICY percentage of 11.45% while the TGA with the nation's highest WICY percentage - Baton Rouge, LA - stands at 41.44%. However, there is evidence that the proportion of women with AIDS in the EMA may be increasing, with women making up 9.2% of new AIDS cases diagnosed between January 1, 2009 and December 31, 2011. Because of their high representation within the San Francisco population, **transgender persons** also make up a significant percentage of PLWHA, with at least 500 transgender individuals - the vast majority of them male-to-female - estimated to be living with HIV or AIDS as of December 31, 2011, representing 2.2% of the region's PLWHA caseload.¹⁰

Current Age: A rapid growing proportion of persons living with HIV and AIDS in our region are age 50 and above. This is attributable both to the long history of the HIV/AIDS epidemic in our EMA, resulting in a large proportion of long-term survivors, and the region's hard-fought success in bringing persons with HIV into care and prolonging the length of their lives. As of December 31, 2010, **nearly half of all persons living with HIV/AIDS in the EMA (45.6%) are age 50 or older, including 432 PLWHA age 70 and older and at least 57 PLWHA age 80 or older. Persons 50 and older now make up the majority of persons living with AIDS in our EMA, constituting 55.9% of the PLWA population as of the end of 2011 (n=6,467).** Between December 2006 and December 2011 alone, the number of persons 50 and over living with AIDS increased by 16.4% within the EMA (from 39.5%), while the overall number of PLWA as a whole increased by only 4.4% (from 11,088). This growing aging population creates dramatic challenges for the local HIV service system, including the need to develop systems to coordinate and integrate HIV and geriatric care and to plan for long-term impacts of HIV drug

Figure 3.
Women, Infants, Children & Youth as a Percentage of Total PLWHA Population for the 15 EMAs/TGAs in the US with the Lowest WICY Percentage as of 12/31/2008

Las Vegas, NV	19.87%
Sacramento, CA	19.74%
San Antonio, TX	18.99%
Kansas City, MO	18.68%
Phoenix, AZ	15.90%
Riverside / San Bernardino, CA	15.44%
Orange County, CA	15.27%
San Jose, CA	15.02%
Los Angeles, CA	14.98%
Portland, OR	13.27%
Seattle, WA	12.48%
San Diego, CA	12.18%
Santa Rosa, CA	12.11%
Denver, CO	11.45%
San Francisco, CA	7.95%

therapies. The largest proportion of persons living with HIV and AIDS in the EMA remain those between the ages of 40 and 49, who make up **35.5%** of the combined PLWHA population, and **35.6%** of new AIDS diagnoses between January 1, 2009 and December 31, 2011. But persons between the ages of 50 and 59 are close behind, making up **31.0%** of all PLWHA in the EMA. A total of **300** young people between the ages of 13 and 24 are estimated to be living with HIV/AIDS in the EMA, constituting **1.3%** of the PLWHA population. However, young people ages 13-24 make up **5.8%** of all new AIDS cases diagnosed between January 1, 2009 and December 31, 2011, pointing to a growing HIV incidence within this population. Only 2 children age 12 and under are known to be living with HIV or AIDS in the EMA, and **no** new AIDS cases were diagnosed among this group between January 1, 2009 and December 31, 2011.

The chart below summarizes the total number of new AIDS cases reported within the past three calendar years from 2009 through 2011.

Number of new AIDS Cases Reported in San Francisco EMA - 2009 - 2011		
CY 2009	CY 2010	CY 2011
397	367	354

Disproportionate Impact: In terms of ethnic minority representation, both African American and Caucasian populations are **disproportionately affected** by HIV in relation to the overall EMA population, while Latino and Asian/Pacific Islander are **underrepresented** in relation to the general population. Certainly the most dramatic over-representation occurs among **African Americans**. While only **4.3%** of EMA residents are African American, they make up **13.5%** of combined PLWHA populations in the San Francisco EMA are African American, meaning that **more than three times** the percentage of African Americans are infected with HIV as their proportion in the general population. And while **61.4%** of all PLWHA are white, only **46.7%** of EMA residents are white. By contrast, Asian/Pacific Islanders make up **26.7%** of the EMA's total population but comprise **5.3%** of PLWHA cases while Latinos constitute **17.4%** of PLWHA but make up **19.3%** of EMA residents. However, new HIV cases will soon create a disproportionate impact among Latinos as well, with **20.8%** of newly diagnosed AIDS cases occurring among Latinos between January 1, 2009 and December 31, 2011.

Homeless and formerly incarcerated individuals are also significantly over-represented among persons living with HIV and AIDS in our region. While the combined annual EMA-Wide Homelessness Rate is estimated at **1,571** per 100,000, including an estimated **13,500** chronic homeless and another **13,140** individuals who become homeless at some point each year,¹¹ the combined annual EMA-Wide homelessness rate among persons living with HIV and AIDS is estimated at **7,999** per 100,000¹² - a rate **more than four times** the rate of homeless among the general population. Meanwhile, according to the Center on Juvenile and Criminal Justice, a total of **6,459** EMA residents were detailed are county jails or state prisons as of December 31, 2010,¹³ while more than **43,000** annual bookings take place in the three-county region in 2010.¹⁴ While available reports do not reveal how many of these arrested are among **unduplicated** persons, a conservative estimate based on prevailing recidivism rates would be **17,500** unduplicated individuals arrested and incarcerated each year in the EMA, for an estimated total of **50,000** individuals spending time in incarceration facilities over the past three years - a rate of **2,815** per 100,000. According to Ryan White service data for **Forensic AIDS Project** – the local Center of Excellence serving recently incarcerated persons - a total of at least **623** unduplicated

individuals incarcerated in the San Francisco County jail were HIV-positive and receiving Ryan White services between July 1, 2009 and June 30, 2012 representing **8.1%** of the city's total Ryan White caseload of 7,660 clients as of February 28, 2012, for a three-year incarceration rate of 8,133 per 100,000 – a rate **more than three times** that of the general population.

The epidemic's most disproportionate impact remains among **gay and bisexual men**. At least 63,577 gay-identified MSM live in the San Francisco EMA,¹⁵ and an estimated 19,784 of them were HIV infected as of December 31, 2011. **This means that a startling 31.1% of all gay-identified MSM in the San Francisco EMA may already be HIV-infected, setting the stage for a continuing health crisis that will impact the future of our region for decades to come.** By contrast, less than **0.4%** of heterosexual men are estimated to be HIV-infected in the San Francisco EMA.

Underrepresented Populations in the Ryan White System: Compared to their proportion of HIV/AIDS cases, **women, persons of color, heterosexuals, and transgender people are over-represented** in the local Ryan White-funded system, while **whites, men, and MSM are underrepresented** due largely to higher average incomes and higher rates of private insurance. For example, while women make up only **6.5%** of all PLWHA in the EMA, they comprise **11.7%** of all Ryan White clients as of February 28, 2012. Meanwhile, while whites make up **61.4%** of all PLWHA in the EMA, they comprise **45.5%** of Ryan White clients as of the same date. Ryan White clinics provide primary medical care to a population that is disproportionately made up of persons of color, women, persons with low incomes, the homeless, heterosexuals, and injection drug users. Additionally, Part D programs operated by Larkin Street Youth Services and the Family Service Network primarily serve young people and women, while Part C programs operated by the San Francisco Clinic Consortium serve the full spectrum of clients, including the homeless, persons of color, women, and gay/bisexual men. Fully **20.9%** of Ryan White clients in the San Francisco EMA are African American as compared to **13.5%** of all persons with HIV/AIDS in the EMA, while San Francisco's seven **Centers of Excellence** which focus on underserved and hard-to-reach populations serve a population that is **30.6%** African American.¹⁶ Women, representing **6.5%** of the total PLWHA population, make up **21.7%** of all Centers of Excellence clients. Transgendered people make up **3.0%** of persons served through the Ryan White system and **5.4%** of persons served through Centers of Excellence while making up **2.2%** of all persons living with HIV and AIDS in the EMA. **All of these statistics highlight the progress the San Francisco EMA has made in reaching and bringing into consistent care the most impoverished and highly underserved HIV-infected residents of the region.**

EMA Service Gaps: According to the recently completed 2010-2011 Unmet Need Framework (see Section 1.g below), an estimated total of **2,245** HIV-aware individuals in the San Francisco EMA were **not** receiving HIV primary care as of June 30, 2011, representing **11%** of the region's total HIV-aware population (n=20,129). This is a significant reduction from last year's estimate, in which **2,898 (14%)** HIV-aware individuals were estimated to not be receiving HIV primary care, and a dramatic reduction from FY 2008-2009, when **5,205 (23%)** were estimated to be out of care. **These reductions are reflective of our ongoing success in identifying, referring, and linking new HIV-positive persons to care.** Between March 1, 2011 and February 28, 2012, at least **7,660** individuals were receiving Ryan White services in the EMA, representing an impressive **42.8%** of the region's combined PLWHA population in care (n=17,884) and **33.1%** of the PLWHA population (n=23,156).

In 2008, the San Francisco EMA commissioned and completed a **Comprehensive HIV**

Health Services Needs Assessment, which included in-depth client surveys completed by 248 PLWHA in all three counties and a series of 4 population-specific focus groups involving monolingual Spanish-speaking persons; persons age 55 and older; Marin County residents; and formerly incarcerated individuals.¹⁷ The Needs Assessment revealed that the local system of care was **extremely successful** in meeting HRSA core service needs among HIV-infected persons who have low incomes, with fully **95%** of survey respondents reporting that their last health care visit for HIV/AIDS had been within the past six months. While the majority of needs assessment respondents stated that they were able to access needed care services, challenges and barriers to health and supportive services that respondents “always” or “sometimes” experience included: a) **transportation (12.7% always / 30.5% sometimes)**; b) **service hours (6.8% always / 35.0% sometimes)**; c) **cultural sensitivity (3.8% always / 15.3% sometimes)**; and d) **language (3.0% always / 9.7% sometimes)**. In regard to housing, **21%** of survey respondents met the criteria for being **homeless** - including **4%** living on the streets or in a car - while **12%** of respondents did not have health coverage of any kind.

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

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

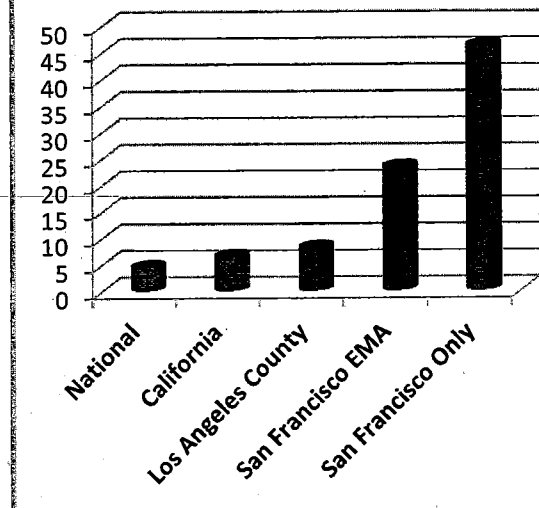
1.b.ii) Narrative on Cost and Complexity of Providing Care

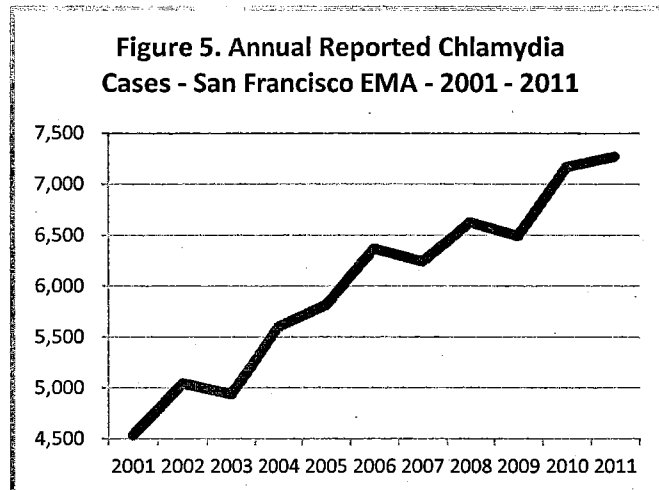
Sexually Transmitted Infection (STI) Rates: The growing crisis of **sexually transmitted infections** is of significant concern for the future of the HIV epidemic in our region. In terms of **syphilis**, for example, the San Francisco EMA continues to confront a major epidemic that has been escalating for the past half decade, rising **more than 500%** since 2000. In 2011, a total of **415** new primary and secondary syphilis cases were diagnosed in the EMA, representing an **81.2% increase** over the **229** cases reported just five years earlier in 2007.¹⁸ The combined EMA-wide syphilis rate of **23.4** per 100,000 in 2011 was nearly **four times** the 2011 statewide rate of **6.5**. Within the City of San Francisco alone, a total of **376** new syphilis cases were reported in 2011 for an incidence rate of **46.2**

cases per 100,000, a rate **more than seven times higher** than the statewide average and **more than ten times higher** than the national syphilis rate of **4.3** cases per 100,000 in 2010 (see Figure 4). **San Francisco County has by far the largest syphilis infection rate of any county in California**, more than **five times** the rate of the next highest county, Alameda County (**9.0** per 100,000) and nearly **six times** that of Los Angeles County (**8.2** per 100,000).¹⁹

The EMA is also experiencing a significant **gonorrhea** epidemic. A total of **2,559** new gonorrhea cases were identified in the San Francisco EMA in 2011, for an EMA-wide incidence of **144.08** cases per 100,000, a rate that is nearly **100% higher** the 2011 California rate of **73.1** cases per 100,000.^{20 21} The city of San Francisco's 2011 gonorrhea incidence of **276.5** cases per 100,000 (n=2,251) is **nearly three**

Figure 4. New Primary & Secondary Syphilis Cases Per 100,000 Population - Selected Metropolitan Areas, 2011





times the national rate of **100.8** cases per 100,000 and **more than ten times higher** than the rate for the State of California as a whole, and is again by far the highest rate of any county in California, with the next highest county – Fresno County - having a case rate that is roughly **half** that of San Francisco (**127.2** per 100,000). Many of the EMA's new gonorrhea cases are occurring among **young women aged 15 – 24**, who accounted for **188** cases in 2010. The gonorrhea rate of **318.6** per 100,000 among 15-24-year-old women in the city of San Francisco is **136% higher** than the

statewide rate of **233.2** per 100,000.²²

The San Francisco EMA's **Chlamydia** epidemic also continues to rise precipitously. A total of **7,272** new cases of Chlamydia were diagnosed in the San Francisco EMA in 2011. This represents a **25.0% increase** over the **5,816** cases diagnosed in 2005 and a **46% increase** since 2001 (see Figure 5).²³ The 2011 EMA-wide Chlamydia incidence stood at **409.4** per 100,000, while the rate for the City of San Francisco was **586.9** cases per 100,000. By comparison, the 2009 incidence for California was **438.0** cases per 100,000 while the national rate was **426.0**. The rate of Chlamydia among young women ages 15-24 is similarly high in the city of San Francisco, with the **1,204** new Chlamydia cases diagnosed among this population in 2011 representing an incidence rate of **4,335** per 100,000, a rate **160% higher** than the statewide rate of **2,696** within this population.²⁴

The cost of treating STIs adds significantly to the cost of HIV care in the San Francisco EMA. According to a study which estimated the direct medical cost of STIs among American youth, the total annual cost of the **9 million** new STI cases occurring among 15-24 year olds totaled **\$6.5 billion** in the US, at a per capita cost of **\$7,220 per person**.²⁵ Lissovoy, et al. estimated US national medical expenditures for congenital syphilis for the first year following diagnosis at between **\$6.2 million** and **\$47 million** for **4,400** cases, or as high as **\$10,682** per case.²⁶ A study published in the *American Journal of Public Health* estimated that a total of **545** new cases of HIV infection among African Americans could be attributed to the facilitative effects of infectious syphilis, at a cost of about **\$113 million**, or a per capita cost of **\$20,730**.²⁷ Such studies suggest that the total cost of treating new STIs in the SF EMA may be as high as **\$14.12 million** per year, including an estimated **\$2.90 million** to treat STIs among persons with HIV, with another **\$4.5 million** in annual costs potentially resulting from the need to treat persons infected with HIV as a result of transmission facilitated through other STIs.²⁸

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

Because of the prohibitively high cost of housing in the San Francisco EMA and the shortage of affordable rental units, the problem of homelessness has reached crisis proportions, creating formidable challenges for organizations seeking to serve HIV-infected populations. According to the National Low Income Housing Coalition's *Out of Reach 2012* report, Marin, San Francisco, and San Mateo Counties – the three counties that make up the

Figure 6.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs, 2011

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

San Francisco EMA – are tied with one another as the three least affordable counties in the nation in terms of the minimum hourly wage needed to rent an average two-bedroom apartment, which currently stands at **\$36.63 per hour** (see Figure 6).³⁰ Meanwhile, as of 2012, the City of San Francisco has the **highest HUD-established Fair Market Rental rate in the nation** at \$1,795 per month for a 2-bedroom apartment, which represents the amount needed to “pay the gross rent of privately owned, decent, and safe rental housing of a modest nature”.³¹

On January 27, 2011, the City of San Francisco conducted its bi-annual 24-hour homeless count which identified a total of **6,455** homeless men and women living on the streets or in jails, shelters, rehabilitation centers, or other emergency facilities, a slight decrease from the 2009 total of **6,514**.³² At the same time, the 2011 San Mateo County Homeless Census and Survey identified a total of **2,149** homeless people on the night of January 26, 2011, including **1,162** unsheltered homeless people living on streets and **987** sheltered homeless people³³ while recent estimates place the number of homeless people in

Marin County from as low as **1,770** to as high as **6,000**.³⁴ The City of San Francisco also serves an additional **3,000 - 7,000** temporarily homeless individuals per year, which means that - with anywhere from **9,500 to 13,500** homeless per year - the city has the **second highest per capita homelessness rate of any city in the U.S.**³⁵ A recent study by the University of California San Francisco found that the City's chronic homeless population has also continued to age, with a current median age among these groups estimated at **50** - up from **37** years of age when population studies first began in 1990.³⁶ Aging augments the progression of chronic diseases related to homelessness, including high rates of diabetes and hypertension, and complicates the problem of providing care to these groups. It is estimated that **23,540** individuals experience homelessness at some point during the year in the EMA, including an estimated **10,500** chronically homeless individuals and **13,040** temporarily homeless persons.

Homelessness has a distinct and well-established link to HIV disease. HIV prevalence studies among homeless adults in San Francisco have produced estimates ranging from a **9%** HIV prevalence rate among the general homeless adult population³⁷ to an astounding **41%** among marginally housed adult MSM.³⁸ Among the hundreds and possibly thousands of homeless youth in San Francisco - a city which still serves as a Mecca for runaway and low-

income young people - estimated HIV prevalence ranges from **29%** among young homeless gay and bisexual males³⁹ to **68%** among gay and bisexual male teens who enter homeless youth centers.⁴⁰ **HIV disease itself also frequently results in homelessness, with the percentage of persons who were homeless at the time of AIDS diagnosis increasing in the City of San Francisco from 9% in 2006 to 14% in 2010, a more than 150% increase.**⁴¹ Persons who were homeless at the time of their HIV diagnosis over this period were more likely to be women, transfemale, African American, and IDU.⁴²

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

Insurance Coverage: The advent of health care reform through the Affordable Care Act (ACA) promises significant, positive change in regard to the number and proportion of low-income persons in our state and region who benefit from health insurance coverage. California is now in the process of implementing its “Bridge to Reform” Section 1115 Medicaid Demonstration Waiver program whose **Low Income Health Insurance Program (LIHP)** is expected to extend Medicaid coverage to approximately **1.4 million** of the nearly 7 million uninsured in California by 2016, a **10%** increase over current levels. However, while creating important change, the problem of lack of insurance continues to be a major barrier to care at the time of this writing, and the future of coverage is uncertain for many populations. According to the most recent data from the UCLA Center for Health Policy Research, at the end 2009 fully **12.4%** of San Francisco EMA residents under the age of 65 were without **any** form of insurance coverage - including Medicaid - for a total of at least **219,466** uninsured individuals under age 65 in our region.⁴⁶ This includes an estimated **16.4%** uninsured in San Francisco; **12.8%** uninsured in San Mateo County; and **9.9%** uninsured in Marin County, for an EMA-wide uninsured incidence of **12,400** among persons under age 65.

The lack of health insurance places extreme financial burden on the system, particularly in the San Francisco EMA, which has extremely high medical costs. In addition, because of the current financial crisis, the numbers of persons who have lost private insurance as a result of unemployment or reduced employment based health insurance benefits has dramatically increased the number of uninsured persons in the State over the past two years.

While approximately **half** of San Francisco Ryan White system clients are covered by Medicaid, roughly **one-quarter** lack **any** form of insurance coverage. At the same time, for those persons with HIV not in care or unaware of their HIV status, the uninsured rate is believed to be much higher than the general population as many HIV-infected people in the EMA are poor, not in care, and/or have not yet applied for Medicaid. SF DPH estimates that the **cost** to the system of serving uninsured and indigent populations living with HIV is at least **\$86.7 million** annually, based on an average **25.1%** uninsured rate among PLWHA in care (n=4,328) at an estimated annual avg. cost of **\$20,000** per person for HIV treatment and medications.

Poverty: The problem of homelessness is closely tied to that of **poverty**, and presents another daunting challenge to the HIV care system. According to the US Census Bureau, between 2006 and 2010 the average percentage of persons living at or below federal poverty level stood at **9.2%** for the entire San Francisco EMA. Using this data, SF DPH projects that at least **490,201** individuals in the San Francisco EMA are living at or below 300% of Federal Poverty Level, which translates to **27.6%** of the overall EMA population lacking resources to cover all but the most basic expenses. **However, because of the high cost of living in the San Francisco Bay Area, persons at 300% of poverty or below have a much more difficult time surviving in our area than those living at these income levels in other parts of the U.S.** Analyzing data from the San Francisco AIDS Regional Information and Evaluation System (ARIES), the SF EMA's client-level data system, it is estimated that at least **68.9%** of all persons living with HIV/ AIDS in the San Francisco EMA (n=15,786) are living at or below 300% of the 2012 Federal Poverty Level (FPL) including persons in impoverished households. **100%** of Ryan White-funded clients live at or below 300% of poverty.⁴⁷ ARIES data reveals that **45.2%** of active Ryan White clients in San Francisco are currently living on incomes of **less than \$10,000 per year** and **17%** are surviving on incomes of less than \$5,000 per year. HIV-infected persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **\$69 million** in Part A and non-Part A HIV-related expenditures in the San Francisco EMA each year.⁴⁸

1.b.iii) Impact of Recently Incarcerated Individuals

The San Francisco EMA HIV care system provides services to a large number of formerly incarcerated individuals whose significant needs pose additional challenges. As noted above, the California Department of Corrections reports that an average total of **17,500** unduplicated individuals are estimated to be arrested and incarcerated each year in the EMA, while a minimum of **65,000** annual bookings take place in the three-county region. As noted above, data for Forensic AIDS Project reveals that at least **623** unduplicated individuals incarcerated in the San Francisco County jail were HIV-positive and receiving Ryan White services between July 1, 2009 and June 30, 2012, representing **8.1%** of the city's total Ryan White caseload of **7,660** clients as of February 28, 2012, for a three-year incarceration rate of **8,133** per 100,000 – a rate **more than three times** that of the general population. Transitions between the community and incarceration often greatly impact an individual's ability to access and remain in HIV care and treatment, and to stabilize life circumstances that promote wellness.

The San Francisco EMA is also home to **San Quentin State Prison**, California's oldest and largest prison. Opened in 1852, the prison houses an average daily population of **5,222** inmates in facilities originally designed to house 3,317 individuals. The prison also serves as the identification point for a large number of persons with HIV, many of whom are paroled to the Bay Area and seek HIV services following release. Over a three year period from January 1, 2009 through December 31, 2011 a total of **13** new AIDS cases diagnosed at San Quentin Prison, while a total population of **364** persons living with HIV and AIDS were served by the prison as of December 31, 2011. More than **half** of these inmates (**51.6%**) were infected through injection drug use, including MSM injection drug users, as compared to **20.6%** of all persons living with HIV/AIDS in the EMA. **African Americans** are highly overrepresented among the San Quentin HIV population, representing **50.3%** of all PLWHA at the facility as of 12/31/11.

An analysis of epidemiological and client data reveals a range of factors that are strongly associated with significantly increased cost and complexity of care for formerly incarcerated populations with HIV in the Bay Area. For example, of the **623** HIV-positive individuals served

by Forensic AIDS Project and released from SF jails in the three years through June 30, 2012, **12.7% were women** – double the percentage of women living with HIV/AIDS in the EMA (6.5%) – and **4.7% were transgender persons** – more than double their representation among the EMA’s total PLWHA population (2.2%). Reflecting high rates of injection drug use among incarcerated populations, **27.9%** of persons with HIV in the SF jail system had been infected through injection drug use alone, as compared to **6.9%** of the overall PLWHA population, while MSM / IDU cases accounted for **18.6%** of jail populations, versus **13.7%** of all PLWHA. These findings are mirrored in a study of young injectors under age 30 in San Francisco, which found that **86%** had a lifetime history of incarceration; **56%** had been incarcerated in the past year; and **42%** were infected with hepatitis C – a critical marker of potential HIV infection.⁴⁹ Equally alarming is the over-representation by **African Americans** among formerly incarcerated persons with HIV in SF, who account for **47.5%** of all PLWHA diagnosed with HIV or provided with HIV care in San Francisco jails, despite making up **13.5%** of the total PLWHA population.

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

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

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

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

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

Coordination with Other Federal and State Resources: The San Francisco HIV Health Services Planning Council and the SF Department of Public Health work together to ensure that Ryan White Part A funds are coordinated across all applicable funding streams in the region. As with the Ryan White streams listed above, the Planning Council reviews annual service category summaries that include a detailed listing of all non-Ryan White funding sources for each

category, including sources such as ADAP, Medicaid and Medicare support, public entitlement programs, private insurance and HMO support, Veterans Administration programs, City and County funds, HOPWA and SAMHSA grants, and State mental health funds. The Grantee also ensures that services are coordinated to maximize the number and accessibility of services, while seeking every possible alternate source of funding apart from Part A to support HIV care.

The most important complementary funding stream to support HIV care for populations with low incomes is the **Medicaid** system, or **Medi-Cal**, as the system is known in California. Medi-Cal is an indispensable link in the chain of support for persons with low-incomes and HIV in the San Francisco EMA. Based on a report prepared by the State Medi-Cal Office summarizing Medi-Cal expenditures in the San Francisco EMA for the first six months of 2012, we project that for calendar year 2012, a total of **\$99,909,988** in HIV-specific Medi-Cal expenditures will be incurred across the EMA's three counties. **Just under one-half (46.0%)** of HIV Medi-Cal expenditures in the EMA are projected to be for **HIV-related medications (\$45,932,154)**; another **8.7% (\$8,706,066)** for **inpatient care**; and **18.2% (\$18,205,732)** for **intensive and skilled nursing care**. The remaining **27.1%** will be dispersed among other categories. A total of **5,339** unduplicated HIV-positive individuals were listed as Medi-Cal recipients for the period January 1 – June 30, 2012. The SF HIV Health Services Planning Council examines changes in Medi-Cal data each year and considers this information in allocating Part A primary medical care funding.

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

- **The AIDS Drug Assistance Program (ADAP)** provides a major source of income for HIV care in California, supporting the costs of a diverse formulary for tens of thousands of low-income California residents. According to NASTAD's 2012 National ADAP Monitoring Report, ADAP drug purchase expenditures in California for fiscal year 2010-2011 totaled **\$442,365,811**, by far the largest ADAP budget in the nation and **50% higher** than the next highest state, New York, at \$294,671,443.⁵¹ At the same time, California's state contribution to the program totaled **\$82,625,000**, also by far the largest contribution by any state in the nation, making up **one-quarter (25.1%)** of combined state ADAP contributions nationally. A total of **39,481** Californians were enrolled in ADAP as of June 2011, versus 21,691 for the state of New York, the next highest state. While California has continually demonstrated its unwavering support for ADAP – most recently in the 2011-2012 State budget – the future of ADAP is far from certain. Even a slight funding reduction would have drastic consequences for the tens of thousands of individuals who rely on this funding to keep them alive.
- Veterans in the EMA are able to access care at **three Veterans Administration (VA)** clinics in the EMA: the Infectious Diseases Clinic at the San Francisco VA Medical Center, offering primary medical care to PLWHA along with access to clinical trials and research; the VA outpatient clinic in the South of Market area in San Francisco; and the Palo Alto VA Center located just outside the EMA, with a satellite clinic in Menlo Park in San Mateo County which is co-located with a public Part A-funded clinic.
- **Housing Opportunities for Persons with AIDS (HOPWA)** services are coordinated through the HOPWA Loan Committee, which includes two Planning Council representatives. For FY 2021, the total HOPWA allocation for the San Francisco EMA totals **\$9,775,600**, including **\$8,564,000** for San Francisco County; **\$873,900** for San Mateo County; and **\$337,700** for Marin County.

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

Coordination with Other Ryan White Act Programs: The San Francisco EMA is dedicated to ensuring the integration and coordination of **all** sources of Ryan White funding in the region. The Health Services Planning Council prioritizes the use of Ryan White funds for services that are not adequately funded through other reimbursement streams to ensure that Part A funds are the funding source of last resort. During each year's priority setting and allocation process, the Grantee produces detailed fact sheets on each service category that include a listing of **all** other funding streams available for that category, including Part B, C, D, and F programs, ADAP, and MAI funding. The Planning Council also assists in the planning for Part B-funded services: The Planning Council works with other local planning groups such as the HIV Prevention Planning Council and Long Term Care Coordinating Council to coordinate services and eliminate duplication. The figure below details complementary Ryan White contributions in the San Francisco EMA during the most recent 12-month contract period (see Figure 7).

Figure 7. Table of Complementary Ryan White Funding – San Francisco EMA Most Recently Completed 12-Month Funding Cycles

Local Jurisdictions	Ryan White Funding Categories & Amounts					H.U.D.
	Part A MAI	Part B	Part B MAI	Part C	Part D	HOPWA
San Francisco Co.	\$797,140	\$2,821,439	\$96,000	\$1,121,810	\$522,553	\$ 8,564,000
San Mateo Co.		\$278,134	\$26,000			\$ 873,900
Marin Co.		\$139,230	\$26,000			\$ 337,700
TOTAL	\$797,140	\$3,238,803	\$148,000	\$1,121,810	\$522,553	\$ 9,775,600

1.d) Assessment of Populations with Emerging Needs

As a highly diverse and complex region with an expanding HIV caseload, the San Francisco EMA is home to many populations with emerging needs, including women, youth, and transgender people; members of distinct ethnic, cultural, and linguistic groups; homeless and

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

Emerging Population # 1: Persons With HIV 50 Years of Age and Older: In part because it was one of the first regions hard hit by the HIV epidemic and in part because of its success in ensuring that a large proportion of persons with HIV have access to the high quality treatments and therapies, the HIV-infected population of the San Francisco EMA continues to age dramatically, at levels beyond which could have been imagined in the first decade of the epidemic. **As of December 31, 2011, nearly half of all persons estimated to living with HIV and AIDS in the San Francisco EMA (45.6%) were 50 and older (10,565 persons).** This represents an **8% increase** over the 9,787 PLWHA 50 and older only one short year ago. **At the same time, for the third year, persons 50 and older make up more than half of all persons living with AIDS in the EMA (6,467 out of 11,578 persons / 55.9%).**

An analysis conducted for this application of the **9,684** persons age 50 and above **confirmed** to be living with HIV/AIDS in the San Francisco EMA as of December 31, 2011 (see Figure 8) reveals many startling facts about this population, including the fact that there are **396** PLWHA

**Figure 8.
Persons Living with HIV/AIDS Age 50 and Above in
the San Francisco EMA as of 12/31/11
(Confirmed Cases Only)**

Demographic Categories	Number	Percent
Gender		
Male	8,995	92.9%
Female	552	5.7%
Transgender	137	1.4%
Current Age		
50 - 59 Years	6,582	68.0%
60 - 69 Years	2,654	27.4%
70 - 79 Years	396	4.1%
80 and Above	52	0.5%
Ethnicity		
White	6,684	69.0%
African American	1,444	14.9%
Latino	1,118	11.5%
Asian / Pacific Islander	302	3.1%
Other / Unknown	136	1.4%
Transmission Categories		
MSM	7,121	73.5%
Injection Drug Users	823	8.5%
MSM Injection Drug Users	1,200	12.4%
Non-IDU Heterosexuals	300	3.1%
Other / Unidentified	240	2.5%
Time Since 1st HIV Diagnosis		
1 - 2 Years	336	3.5%
3 - 5 Years	496	5.1%
6 - 10 Years	1,363	14.1%
11 - 15 Years	2,348	24.2%
16 - 20 Years	2,791	28.8%
More Than 20 Years	2,328	24.2%
TOTAL	9,684	100.0%

age 70 and above in SF, including 52 persons age 80 and above. The 50 and over population in San Francisco also contains a slightly higher percentage of African Americans than in the PLWHA population as a whole (14.9% vs. 13.5%), along with a higher proportion of non-MSM injection drug users (8.5% vs. 6.9%). For the first time, we also analyzed length of time since initial HIV diagnosis and found that **more than two-thirds** of the 50 and older population (77.3%) had been living with HIV for 11 or more years, and that nearly **one-quarter** (24.2%) were long-term survivors who had been living with HIV infection for 20 years or more.

Because HIV medications are still relatively new, it is not yet known either what the long-term effects of HAART will be on older persons with HIV or how traditional health issues related to aging and geriatric health may interact with or complicate HIV treatment and care. Aging populations will certainly present challenges to the health care system in terms of devising new strategies for providing integrated HIV and geriatric care, and for meeting the long-term needs of clients with increasingly complex needs. At the same time as a result of previous employment, many older long-term survivors living with HIV/AIDS who have had the advantage of long-term disability policies will lose those benefits immediately upon reaching Social Security retirement age and may find themselves immediately in poverty, a problem with which the current system is unprepared to deal. The annual cost of providing HIV-related services to persons over 50 years of age within the SF EMA is estimated to be as high as \$169,040,000.⁵²

Emerging Population # 2:

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

Because of the region’s traditional openness to diverse lifestyles, many transgender individuals move to the San Francisco EMA seeking greater acceptance and an expanded sense of community. According to Clements, at least **5,000** transgender persons call the Bay Area home, although precise statistics are not available.⁵⁴

Demographic Categories	Number	Percent
Current Age		
13- 24 Years	11	2.4%
25 - 49 Years	318	68.5%
Age 50 and Above	135	29.1%
Ethnicity		
White	99	21.3%
African American	161	34.7%
Latino	145	31.3%
Asian / Pacific Islander	45	9.7%
Other / Unknown	14	3.0%
Transmission Categories		
MSM	255	55.0%
Injection Drug Users	9	1.9%
MSM Injection Drug Users	191	41.2%
Non-IDU Heterosexuals	6	1.3%
Other / Unidentified	3	0.6%
TOTAL	464	100.0%

What is not in question, however, is the epidemic's growing impact on these populations. As of December 31, 2011, at least **500** transgender persons were living with HIV and AIDS in the San Francisco EMA, although actual numbers are probably much higher, with some studies indicating that HIV infection rates may be as high as **23.8%** among this population, which in San Francisco would mean that at least **1,200** transgender persons may already be living with HIV.⁵⁵ Figure 9 provides a demographic breakdown of **confirmed** male-to-female (MTF) transgender PLWHA in San Francisco County as of 12/31/11 and offers some fascinating insights into the complexity of this population. Perhaps most striking is the **cultural diversity** of transgender PLWHA, with the largest infected ethnic groups being **African Americans (34.7%)** and **Latinos (31.3%)**. Together these groups make up **66.0%** of transgender PLWHA but only **30.9%** of all PLWHA in the EMA. Reflecting the high risk of injection-related infections among transgender persons, fully **41.2%** of transgender PLWHA were infected through combined MSM / IDU behavior, versus **13.7%** for the EMA as a whole.

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

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

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

Emerging Population # 3: Men of Color Who Have Sex with Men (MSM): MSM overall make up by far the most heavily HIV-impacted population in the San Francisco EMA, accounting for **85.4%** of all persons living with HIV and AIDS as of December 31, 2011,

including MSM who inject drugs (n=19,784). At least **6,500** of these individuals - or approximately **one-third** of the HIV-infected MSM population of the EMA - are people of color, most of them **African Americans** and **Latinos**. However, in calendar year 2011 in the city of San Francisco, nearly half of all persons who tested positive for HIV (**48.0%**) were persons of color, an increase of **5.8%** from 2006 (**188** of **392** new HIV infections). Within Latino communities in San Francisco, MSM make up **87.3%** of all persons living with HIV/AIDS, including **75.7%** infected through MSM contact and **11.6%** infected through MSM contact and injection drug use. Among Asian and Pacific Islander groups, the percentage is even higher, with MSM accounting for **87.7%** of all persons living with HIV/AIDS, including **78.6%** MSM only cases and **9.2%** MSM/IDU cases. The percentage of MSM cases among African Americans in San Francisco is somewhat lower, largely due to the fact that a much higher proportion of African Americans living with HIV and AIDS are women.

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

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

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

31, 2011, a total of 3,123 African Americans were estimated to be living with HIV/AIDS in the EMA, representing 13.5% of the region's HIV-infected population, despite the fact that only 4.3% of the EMA's population is African American. At the same time, fully 17.7% of all those newly diagnosed with AIDS between January 1, 2009 and December 31, 2011 were African American – a percentage 31.1% higher than their representation in the overall PLWHA population. Women account for 18.1% of all African American PLWHA in the EMA, as compared to 6.5% for the EMA as a whole, while heterosexually transmitted cases account for 9.7% of African American PLWHA as compared to 3.9% for the entire EMA. At least 30% of all African Americans living with HIV in the San Francisco EMA are currently estimated to be out of care - a proportion comparable to the percentage of homeless persons out of care. The reasons for this under-representation include: a) continuing high rates of stigma within African American communities related both to HIV and the behaviors that transmit it; b) higher prevailing rates of poverty and unemployment, leading to lower rates of private insurance and health care utilization; and c) high rates of injection drug use and homelessness, leading to difficulty in accessing or prioritizing care. Of the 183 African Americans surveyed for the EMA's 2008 Needs Assessment, 49.3% reported having no insurance of any kind, and 53.3% reported a high or complete disconnection from care, with frequently cited barriers including: fear of governmental health services; lack of culturally competent services; racial discrimination; frustration with long waiting lists; and a lower prioritization of health care due to competing needs driven by poverty and racism. To successfully reach more HIV-infected African Americans, the local care system has had to engage in a more aggressive and comprehensive approach by locating culturally appropriate services within historically black neighborhoods to inform African Americans of the importance of HIV testing and proactively engaging them in treatment. **The Black Center of Excellence at the University of California San Francisco, supported with Ryan White Part A funds, are making a significant contribution toward addressing this discrepancy.** In addition, in 2010, the San Francisco Planning Council completed an **African American Women's Needs Assessment** which significantly expanded our understanding of the needs and life circumstances of this population and aided in the prioritization and allocation of service funding. The annual cost of providing HIV-related services to African Americans within the SF EMA is estimated at \$39,348,000.⁶⁰

Emerging Population # 6: Latinos: In the San Francisco EMA, the Latino population makes up a growing percentage of the region's total HIV-infected population. While 17.4% of all PLWHA in the EMA as of December 31, 2011 were Latino/a, 20.8% of new AIDS cases diagnosed between January 1, 2009 and December 31, 2011 were among Latino/as. A total of 4,030 Latino/a PLWHA estimated to be living in the EMA as of the end of 2011. According to the most recent San Francisco HIV Epidemiology Report, Latinos represent 31% of young adult AIDS cases age 20-24 in the city and an alarming 44% of adolescent AIDS cases age 13-19 – a clear overrepresentation when compared to the 26% of the general adolescent population of San Francisco which is Latino/a. As with African American populations, a lack of access to health care, higher rates of poverty and unemployment, and a disconnection from health and social services contribute to relatively high rates of unmet need in the Latino population. According to the US Census, in the City of San Francisco, 11.1% of the city's population speaks Spanish as their primary language, with 26.5% of those who speak Spanish as their primary language reporting they speak English either not well or not at all. This requires that HIV services be provided in Spanish by culturally competent professionals who understand the health beliefs and practices of Latino communities. Fear of jeopardizing naturalization opportunities also leads to a

reluctance to seek HIV testing or treatment. The **Mission Center of Excellence** operated by Mission Neighborhood Health Center and funded through MAI funding provides culturally competent, integrated, bilingual/bi-cultural HIV services to over **400** Mission neighborhood residents, with an emphasis on Spanish-speaking clients, in order to enhance their quality of life and promote individual and community empowerment. The annual **cost** of providing HIV-related services to Latino populations in the SF EMA is estimated at **\$56,218,500**.⁶¹

1. e) Unique Service Delivery Challenges

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

Growing Population of Persons with HIV including Individuals with Multiple Needs:

It is important to remember that despite diminishing financial resources, there are today more persons living with HIV in the San Francisco EMA than at any point in the history of the epidemic - an increase of more than 50% over the last 12 years alone. **This crisis requires increased resources, not reduced ones.** The estimated **23,156** persons living with HIV and AIDS as of 12/31/11 represents **70.0%** of the total 33,099 AIDS cases **ever diagnosed** in the San Francisco EMA, and is **nearly 50% more** than the 22,384 people who had **ever died** from AIDS in the region through the end of 2011. Because of our unparalleled success in bringing large numbers of persons with HIV into care, supporting the cost of their medications and treatment, and providing help for them to remain stable and compliant, persons with HIV in the region are living much longer and more productive lives than would previously have been thought possible. At the same time, they are progressing to AIDS at a slower rate, despite the growing need and complexity of the HIV-infected population. **The reduction in the rate of new annual AIDS cases in the region is a sign of the success of the San Francisco system of care in preventing HIV-infected people from progressing to AIDS.**

But local HIV-infected populations are not only growing – they are becoming much more challenging to serve, presenting a greater range of pre-existing physical, psychosocial, and financial issues than at any point in the past. The characteristics of the local epidemic are staggering: **Two-thirds** of persons living with HIV and AIDS and **one hundred percent** of persons in the Ryan White system are living at or below 300% of federal poverty level;⁶² **One in four** persons with HIV have no form of health insurance;⁶³ Nearly **one in ten** persons newly

diagnosed with AIDS in the EMA is homeless,⁶⁴ As many as **half** of MSM living with HIV in the EMA suffer from depression,⁶⁵ **Thirty percent** of local PLWHA are active substance users;⁶⁶ **One in seven** persons with HIV in the EMA speaks a primary language other than English;⁶⁷ **As many as one-third** of gay-identified men in the San Francisco EMA may be HIV-infected;⁶⁸ and **Thirty-five percent** or more of transgender persons are believed to be HIV-infected, including **over half** of all African American male-to-female transgender persons.⁶⁹

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

Escalating Co-Morbidities: Section 1.b above describes several co-morbidities critical to the complexity of providing care in the San Francisco EMA. However, these are by no means the only key issues contributing to the growing complexity of the HIV epidemic in San Francisco. The problem of **substance use**, for example, plays a central role in the dynamics of the HIV epidemic, creating challenges for providers while presenting a critical barrier to care for HIV-infected consumers. The EMA is in the throes of a major substance abuse epidemic which is fueling the spread not only of HIV but of co-morbidities such as sexually transmitted infections, hepatitis C, mental illness, and homelessness - conditions that complicate the care system's ability to bring and retain PLWHA in care. According to the most recent report by the California Office of Statewide Health Planning and Development, an average of **8.5** hospitalizations per 10,000 occurred in San Francisco, well above the average statewide rate of **6.6** per 10,000.⁷¹ At the same time, the rate for drug-induced deaths in San Francisco stood at **24.8** per 100,000, more than double the statewide rate of **10.8** per 100,000.⁷² Drugs and drug-related poisonings are also the **leading** cause of injury deaths among San Franciscans, **with nearly three San Franciscans dying each week of a drug-related overdose or poisoning.**⁷³ In terms of HIV, the most alarming current threat involves the local epidemic of **methamphetamine (speed).** Health experts currently estimate that up to **40%** of gay men in San Francisco have tried methamphetamine,⁷⁴ and recreational crystal use has been linked to **30%** of San Francisco's new HIV infections in recent years.⁷⁵

The costs associated with the substance addiction epidemic in the San Francisco EMA add significantly to the local burden of HIV care. According to the National Office on Drug Abuse (NIDA), the total costs of drug abuse and addiction due to use of tobacco, alcohol, and illegal drugs are estimated at **\$524 billion** a year and illicit drug use alone accounts for **\$181 billion** in health care costs, lost productivity, crime, incarceration, and drug enforcement.⁷⁶ The National Institute on Drug Abuse reports that it costs an average of **\$3,600 per month** to leave a drug

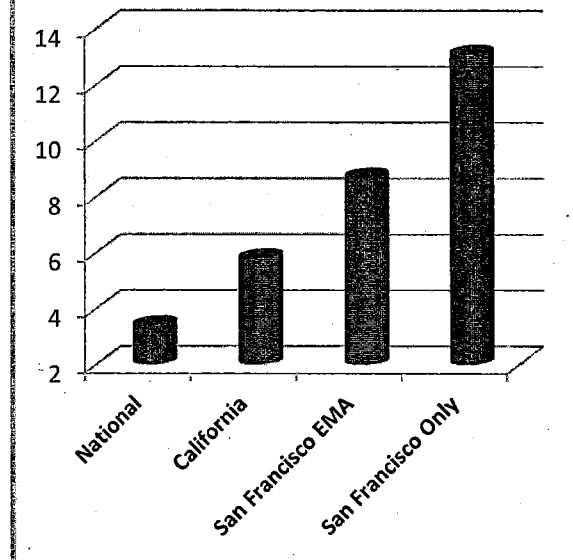
abuser untreated in the community; while incarceration related to substance use costs approximately **\$3,300 per month**.⁷⁷ Such costs can be significantly offset by drug treatment services, which are estimated to save between **\$4 and \$7** for every dollar spent on treatment. An average course of methadone maintenance therapy, for example, costs about **\$290 per month**, while a range of methamphetamine treatment programs in San Francisco cost between **\$2,068 and 4,458** for a single course of treatment.⁷⁸

Injection drug use in the San Francisco EMA is closely related to the growing local epidemic of **hepatitis C**. Because it is a blood-borne infection, hepatitis C is closely tied to injection drug use, and is a frequent co-factor for persons living with HIV/AIDS, complicating care and often leading to severe long-term health consequences. **SF DPH estimates that as many as 90% of all chronic injection drug users over the age of 30 may already be infected with hepatitis C.** Co-infection with hepatitis C can make persons living with HIV unable to tolerate new treatments, and is the leading cause of death from chronic liver disease in America.⁷⁹ Existing hepatitis C treatments are also costly, and are effective for only about **50%** of people who take them. A single 48-week treatment course of injected interferon and oral ribavirin costs more than **\$20,000**.⁸⁰ One study estimated a total of **\$10.7 billion** in direct medical care costs related to HCV in the US for the years 2010 to 2019, along with a combined loss of **1.83 million years of life** in those younger than 65 at a societal cost of **\$54.2 billion**.⁸¹ **The HIV care system is rapidly becoming the default medical provider for many persons with hepatitis C - a trend which, as persons with HCV age, will place enormous cost burdens on the system.**

Tuberculosis (TB) is another critical health factor linked to HIV, particularly in terms of its effects on recent immigrants and the homeless. The magnitude of the local TB crisis is comparable to syphilis and gonorrhea, with a total of **154** new cases of TB diagnosed in the SF Metropolitan Area in 2011, representing an EMA-wide incidence of **8.67** cases per 100,000.⁸² In San Francisco, the incidence is even higher, at **13.1** cases per 100,000. San Francisco County's 2011 TB rate ranked second in California out of 58 counties, while San Mateo ranked sixth and Marin County ranked 18th. **San Francisco's TB incidence rate is more than double than the statewide rate of 5.8 cases per 100,000 and nearly three times higher than the national rate of 3.4 cases per 100,000** (see Figure 10).⁸³ Treatment for **multidrug-resistant tuberculosis** is particularly expensive, with one study indicating that the cost averaged **\$89,594** per person for those who survived, and as much as **\$717,555** for patients who died.⁸⁴

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

Figure 10. 2011 Tuberculosis Cases Per 100,000 Population - Selected Metropolitan Areas



homeless population suffers from some form of mental illness.⁸⁵ In part because of the Golden Gate Bridge, San Francisco also has one of the nation's highest rates of both adult and teen suicide completion, and the rate of suicide per capita in San Francisco is **twice as high** as the city's homicide rate.⁸⁶ When coupled with the second highest incidence of homelessness in the US, these statistics reflect the high incidence of multiply diagnosed clients in the EMA. Among persons with severe mental illness, the research literature documents a broad range of HIV seroprevalence rates, from 4% to as high as 23%.⁸⁷ Mental illness, depression, and dementia are also increasingly common among HIV-diagnosed populations, with 31% of HIV clients at one San Francisco clinic having concomitant mental illness, and 80% of clients at another clinic having a major psychiatric condition. One recent study found a 37% prevalence of depression in HIV-infected men in San Francisco.⁸⁸

Concentration of HIV/AIDS Cases: Imagine standing in a crowded bus or train during rush hour in a major U.S. city. On that train in San Francisco, the odds are extremely high that at least **two** people will have HIV. As noted above, **1 in every 41** residents of the city is currently living with HIV disease, including as many as **one out of every three** gay-identified men. In most major U.S. cities, the burden of the HIV epidemic is spread across a relatively large region, with more facilities available to provide care for broadly dispersed groups of patients. The City of San Francisco, however, is **less than seven miles long by seven miles wide**, which means that this population must be cared for within a very limited space that has fewer health and social service facilities available to meet client needs. In San Francisco, the concentrated demand results in HIV services being compressed within individual provider agencies that are struggling to cope with HIV caseloads many times larger than they were originally established to serve. Lag times between initial inquiries and appointments are becoming progressively longer, and clients are experiencing greater delays in obtaining key services. The increasing complexity of HIV-infected populations also means that local agencies must cobble together combinations of full-time and part-time staff, resulting in higher levels of employee turnover and attrition.

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

The San Francisco EMA experienced a sudden and dramatic decrease in Ryan White Part A funding between the previous and current fiscal year, with support dropping from a total of \$25,640,788 in FY 2011 to \$20,774,722, a loss of nearly \$5 million in one short year. This represents an 18.9% cut in Part A funding to the region, related in part to the hold harmless provision of the Ryan White HIV/AIDS Treatment Extension Act of 2009 which does not include a supplemental funding restoration to the San Francisco EMA for the period 2010 - 2014. While our region was fortunate to have the cuts restored for the current fiscal year out of San Francisco County General Funds, this support is not guaranteed in the future, and is susceptible to dramatic future reductions based on the continuing economic crisis in the State of California. The dramatic reductions in the present fiscal year are on top of a series of reductions in Part A formula and supplemental funds that have stripped nearly 50% of the EMA's combined Ryan White funding over the past decade and a half. Continual reductions in formula and supplemental funding over the past half decade have led to the broadening of waiting lists at a number of key agencies and regional Centers of Excellence – including the Mission Center of Excellence - and to a lack of immediate access to care for newly infected individuals. In July 2008, a highly popular HIV dental clinic located at University of the Pacific in San Francisco was forced to discontinue clinics due to cuts in State Denti-Cal reimbursements, depriving hundreds of low-income HIV-infected men and women of quality dental care. And in early 2012, the city's HIV care system was dealt a significant blow by the closing of Tenderloin Health Services, an agency

specializing in HIV care and support for the San Francisco's most highly marginalized populations. Prior Part A funding reductions also forced the agency Continuum to close its unique adult day care program located in the Tenderloin area of San Francisco and eliminated a medical van transportation service provided by Shanti which has since created significant barriers in accessing care. In Marin County, reductions forced the elimination of the region's Volunteer Services program which provided practical, emotional, and transportation support to clients, including programs for driving clients to medical appointments and training disabled persons with HIV to learn marketable computer skills. Marin County funding cuts also made it unfeasible to contract with the Marin Community Food Bank to provide home-delivered food to homebound clients. Instead, the County's food service now consists of food gift cards made available to only the most severe need clients who must now shop for and prepare their own meals. **To preserve a basic level of care for persons with HIV in the hard-hit Bay Area region, the SF EMA seeks a significant measure of Part A formula and supplemental funding restoration through the FY 2013 allocation process to avoid significant reductions in the quality and length of life of persons with HIV in the region.**

1.G) UNMET NEED

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

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

This year's unmet need analysis included persons living with AIDS (PLWA) and persons living with HIV/non-AIDS (PLWH) in the San Francisco EMA during the 12-month period from **July 1, 2010 through June 30, 2011**. The analysis incorporated an estimate of overall unmet need as well as subpopulation analyses for both PLWA and PLWH. These estimates were produced by the SFDPH HIV Epidemiology Section, and utilize the unmet need framework methodology developed by the University of California, San Francisco Institute of Health Policy Studies – the framework that is specifically recommended by HRSA. The timeframe chosen for the unmet need analysis was based on the most recent 12-month interval for which care data were complete from all available data sources.

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

Population Estimation Methods: Reporting of AIDS cases in the SF EMA is **very complete**. For all counties in the SF EMA, the number of PLWA was derived directly from AIDS cases reported in eHARS. SFDPH calculates the number of PLWH in San Francisco (which contains close to **90%** of the EMA's total PLWA population) and San Mateo based on the actual number of PLWH already contained in eHARS, supplemented by additional PLWH from the California patient care file (described above in Data Sources) and a laboratory data file containing patients with confirmed HIV test results who had not yet been reported in eHARS.

The total number of PLWH documented in these files after unduplicating across data sources was used. The number of PLWH in Marin County was estimated based on two assumptions: (1) a **1-to-1 ratio** of PLWA to PLWH based on consensus estimates obtained in 2010 from HIV/AIDS experts⁸⁹; and (2) an estimation that **66%** of PLWH in the EMA were aware of their HIV infection (based on a recent analysis comparing consensus estimates and case report data). HIV/AIDS populations at San Quentin State Prison in Marin County were excluded from estimates because HIV-infected prisoners at this facility are often transferred out of the county after receiving an HIV diagnosis and do not access the County's private or public health care system while incarcerated. However, their numbers are included in our overall epidemiological table (see Attachment 4) because they receive a diagnosis of HIV within our EMA.⁹⁰

Methods for Estimating Met and Unmet Need for Primary Medical Care: In

accordance with HRSA guidelines, PLWA and PLWH were considered to have a **met** need for HIV primary medical care if any data source indicated that they received antiretroviral therapy or had at least one CD4 or viral load test during the **12-month period from July 1, 2010 through June 30, 2011**. Separate unmet need estimates for PLWA and PLWH were able to be generated as all population and care data sources contained information on AIDS/HIV status. The number of PLWA in care for Marin County and San Mateo was calculated as the number of unduplicated persons who received care based on all data sources. To determine the number of PLWA receiving care in San Francisco, the proportion of PLWA in care using a representative subset of PLWA living in San Francisco County (n=8,446) was calculated. The proportion of PLWA in care was determined primarily based on the date of the last time the patient was seen and recorded by the Health Department. The sample proportion of PLWA in care to the total number of PLWA was then applied to derive the number of PLWA who received care within each of these two counties. For all counties in the EMA, the number of PLWH in care was calculated as the number of unduplicated persons who received care based on all data sources. Estimates for PLWA and PLWH were first derived separately for each of the three EMA counties and then combined to produce the EMA estimates shown in the unmet need table in Attachment 6.

Findings: Estimates of Populations, Persons in Care and Unmet Need from July 1, 2010 through June 30, 2011: An estimated **11,431** PLWA and **8696** PLWH who were aware of their HIV status resided in the S.F. EMA from July 1, 2010 through June 30, 2011 (see Table in Attachment 6). A total of **1,056** PLWA and **1,189** PLWH did not receive primary medical care during that time period. Unmet need was thus **11%** overall, and - as would be expected - was higher among PLWH (**14%**) than among PLWA (**9%**). The 11% overall unmet need estimate is lower than last year's estimate of 14%.

1.g.3) Unmet Need Trends

Reported Percentages of Unmet Need in San Francisco EMA – FY 2009 - FY 2011		
FY 2008-2009	FY 2009-2010	FY 2010-2011
18%	14%	11%

The table above lists percentage of unmet need in San Francisco for the years 2009–2011, based on calculations made for a July 1 – June 30th cycle for each year and reported in each year's Ryan White Part A application. **The table demonstrates a decrease in the percentage of persons with unmet need in the EMA, from 18% in FY 2009 to 14% in FY 2010 to 11% in**

FY 2011. The decrease in unmet need is believed to be based on the EMA's continuing success in aggressively identifying and linking to care persons who had either dropped out of care or who had previously been unaware of their HIV status.

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

Demographics and Location of People Who Know Their HIV Status but are Not in Care: Continually enhanced data collection and reporting systems in the San Francisco EMA have given our region ability to compare specific unmet need among PLWHA. For the period July 1, 2010 through June 30, 2011 we estimated these populations across four critical categories: HIV/AIDS status, gender, race/ethnicity, and age group – results that are reported in Figure 11 on the following page. While San Francisco has pioneered several new approaches to mapping HIV-infected PLWHA in the city using zip codes and census tracts as a way to help target HIV testing outreach and prevention efforts. However, these methods are unreliable in terms of predicting place of residence for persons who are either out of care or unaware of their HIV status, in part because of the transience of persons with HIV in San Francisco and in part because of the extensive in-migration of persons with HIV who travel to the EMA seeking care.

Trends Associated with the Past Three Years Regarding Unmet Need: The table in Section 1.g.3 above lists percentage of unmet need in San Francisco for the years 2009–2011, and demonstrates a continued reduction in the percentage of persons with an unmet need for HIV primary medical care in the San Francisco EMA, from **18%** in FY 2009 to **14%** in FY 2010 to **11%** in FY 2011. As noted above, the decrease in unmet need is believed to be based on the EMA's continuing success in aggressively identifying and linking to care persons who had either dropped out of care or who had previously been unaware of their HIV status. It can also be attributed in part to an ongoing decrease in the number of new persons becoming infected with HIV in the EMA each year, which helps explain why fewer individuals who are living with non-AIDS HIV are unaware of their HIV status. A comparison of this year's data with the unmet need demographics data produced two years ago, for the period July 1, 2008 through June 30, 2009, reveals, for example, that while persons with non-AIDS HIV made up **70%** of the total unmet need population two years ago (n=2,567) they make up only **53%** of the unmet need population this year (n=1,189). At the same time, while the percentage of out-of-care PLWA has increased (from **30%** to **47%**) the actual number of out-of-care PLWA has actually **decreased** over the same two-year period, from **1,115** to **1,056**. Few other significant demographic changes in the out-of-care population have occurred over the past two years, with the exception of a minor increase in the percentage of out-of-care Latinos from **16%** to **17%** and a concomitant decrease in the percentage of African Americans who are out of care from **15%** to **13%**. As expected, the percentage of persons with HIV age 50 and older has continued to increase, rising from **41%** for the period 2008-2009 to **43%** in 2010-2011.

Methods Used to Assess Service Needs, Gaps, and Barriers to Care for People Not in Care: Assessment of service gaps and barriers to care for out-of-care populations remains a critical component of the EMA's comprehensive needs assessment process. The last full-scale needs assessment, conducted in 2008, included a significant focus on persons not in care. Among the key findings of the Assessment related to unmet need were the following: a) **60%** of survey respondents who stated that they were currently out of care were **African American**; b) **100%** of all out of care survey respondents stated that they were living at or below **150% of federal poverty level**; c) **23%** of out of care respondents were **female**; and d) of individuals who had been out of primary medical care for a year or more, only **18%** reported being on antiretroviral treatments, versus **75%** of the overall survey population. At the time of the assessment, these and

