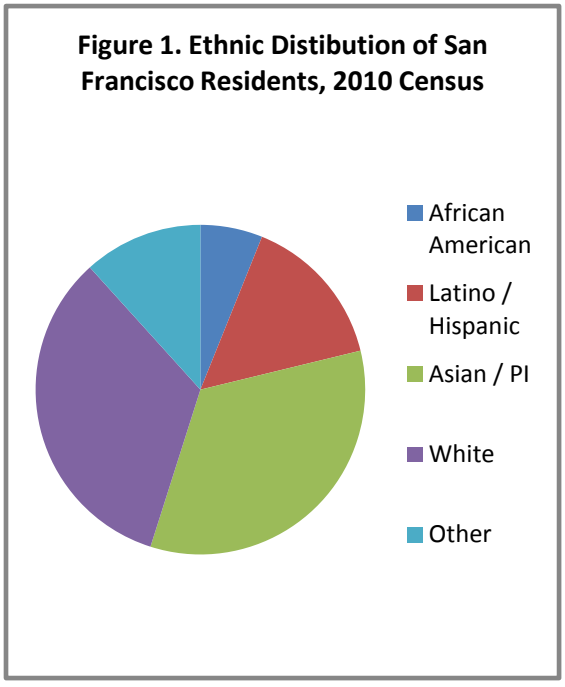
ACHIEVING RESULTS ACROSS THE CONTINUUM OF HIV CARE:
SAN FRANCISCO EMA FY 2015 RYAN WHITE PART A
COMPETING CONTINUATION APPLICATION NARRATIVE

"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

INTRODUCTION

The San Francisco Eligible Metropolitan Area (EMA) respectfully requests a total of **$36,218,233** in Ryan White Part A Formula and Supplemental funding to allow our region to continue to meet the ongoing local crisis of HIV infection in an effective and strategic manner which is fully coordinated within the overarching HIV Continuum of Care. Requested funds will continue to ensure a seamless, comprehensive, and culturally competent system of care focused on the complementary goals of: a) reducing inequities and disparities in HIV care access and outcomes, and b) ensuring parity and equal access to primary medical care and support services for all residents in the region. The FY 2015 Part A Service Plan described in our application strikes a balance between providing an integrated range of intensive health and supportive services for complex, severe need, and multiply diagnosed populations and expanding and nurturing the self-management and personal empowerment of persons living with HIV. The Plan also incorporates expanded integration which HIV outreach, testing, linkage, and care retention services while incorporating the perspectives and input of a broad range of consumers, providers, and planners from across our region, as well as findings of key data sources described below. The FY 2015 Part A application presents a balanced and effective strategy to both preserve and advance a tradition of HIV service excellence in the San Francisco EMA.



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

Marin and San Mateo Counties. In San Mateo County, a mountain range marking the western boundary of the San Andreas Fault bisects the region from north to south, creating challenges for those attempting to move between the county's eastern and western sides. The San Francisco (SF) EMA is also unusual because of the dramatic difference in the size of its member counties. While Marin and San Mateo Counties have a land area of **520** and **449** square miles, respectively, San Francisco County has a land area of only **46.7** square miles, making it **by far the smallest county in California** geographically, and the **sixth smallest county in the US** in terms of land area. San Francisco is also one of only three major cities in the US (the others are Denver and Washington, DC) in which the city's borders are identical to those of the county in which it is located. The unification of city and county governments under a single mayor and Board of Supervisors allows for a streamlined service planning and delivery process.

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

The geographic diversity of the San Francisco EMA is reflected in the diversity of the people who call the area home. Over **half** of the EMA's residents (**53.3%**) are persons of color, including Asian/Pacific Islanders (**26.7%**), Latinos (**19.3%**), and African Americans (**4.3%**). In San Francisco, persons of color make up **58.1%** of the total population, with Asian residents alone making up over **one-third (33%)** of the city's total population (see **Figure 1**). The nation's largest population of Chinese Americans lives in the City of San Francisco, joined by a diverse range of Asian immigrants, including large numbers of Japanese, Vietnamese, Laotian, and Cambodian residents. A large number of Latino immigrants also reside in the EMA, including native residents of Mexico, Guatemala, El Salvador, and Nicaragua. EMA-wide, **31.6%** of residents were born outside the US and **41.7%** of residents speak a language other than English at home with over **100** separate Asian dialects alone spoken in SF. Only **half** of the high school students in the City of San Francisco were born in the United States, and almost **one-quarter** have been in the country six years or less. A total of over **20,000** new immigrants join the EMA's population each year, in addition to at least **75,000** permanent and semi-permanent undocumented residents.

NEEDS ASSESSMENT

1) Jurisdictional Profile

1.A) HIV/AIDS Incidence and Prevalence Table - 2011 - 2013 - See **Figure 2** below

Figure 2. HIV Incidence & Prevalence in San Francisco EMA 2011 - 2013

Reporting Categories	CY 2011	CY 2012	CY 2013
HIV Incidence: Number of new HIV cases reported during calendar year, including persons with AIDS	**506**	**501**	**423**
HIV Prevalence: Number of persons living with HIV at the end of calendar year, including persons with AIDS	**17,787**	**18,082**	**18,332**

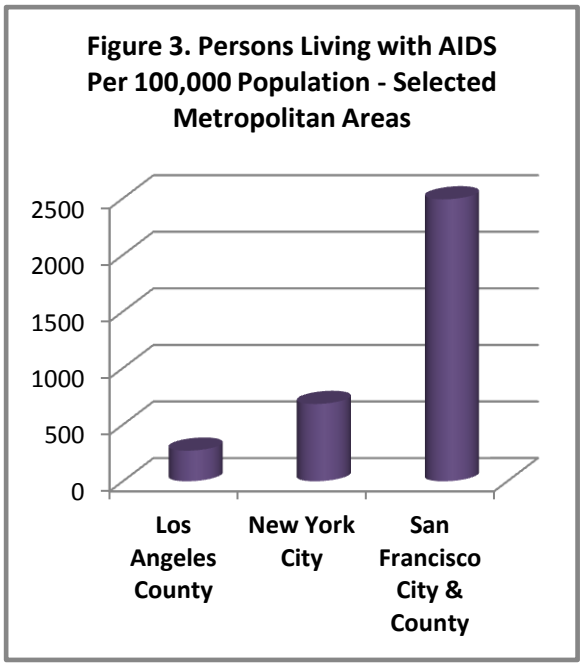
1.B) HIV/AIDS Demographic Table - Please see **Attachment 3**

1.C) HIV/AIDS Epidemiology Narrative

Disproportionate Impact of HIV: More than three decades into the HIV epidemic, the three counties of the San Francisco EMA continue to be devastated by HIV – an ongoing crisis that has exacted an enormous human and financial toll on our region. According to the State of California, as of June 30, 2014, a total of **33,761** cumulative AIDS cases had been diagnosed in the EMA, representing just under **one in five** of all AIDS cases ever diagnosed in the state of California (n=**169,588**).[3] Over **22,978** persons have already died as a result of HIV infection in the EMA. As of December 31, 2013, a total of **18,332** persons were known to be living with HIV infection in the EMA's three counties, including **6,617** persons living with HIV and **11,715** persons living with AIDS. (see Table in **Attachment 3**).[4] This represents an EMA-wide HIV infection incidence of **1,032.2** cases per 100,000 persons, meaning that approximately **1 in every 97 residents of the San Francisco EMA is now living with HIV.** A total of **1,430** new HIV cases were diagnosed in the EMA over the three-year period between January 1, 2011 and December 31, 2013 alone, representing **7.8%** of all persons living with HIV 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 over **20%** over the last decade alone - a percentage that does include more rapidly escalating non-AIDS HIV cases. Through June 30, 2104, a cumulative total of **29,592** cases of AIDS have been diagnosed in San Francisco, accounting for nearly **3%** of all AIDS cases ever identified in the US as of the end of 2011 (n=**1,138,211**) and nearly **18%** of all AIDS cases diagnosed in California, despite the fact that San Francisco County contains only **2%** of the state's population.[7] As of the end of 2013, a total of **15,898** San Franciscans were living with AIDS or HIV, representing **86.7%** of all persons living with HIV/AIDS in the EMA, for a staggering citywide prevalence of **1,974.3** cases of HIV per 100,000. **This means that 1 in every 50 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 2013, the incidence of persons living with AIDS per 100,000 in San Francisco County was over **nearly ten times** that of Los Angeles County (**270.5** per 100,000) and **nearly three times** that of New York City (**820.6** per 100,000) (see **Figure 3**).[8]



The local HIV epidemic's most disproportionate impact remains among **gay and bisexual men**. While the proportionate impact of HIV on MSM has declined over time in other parts of the US, MSM in the San Francisco EMA constitute fully **85.5%** of persons living with HIV/AIDS (PLWHA) in our region (**15,670**), including **13,071** men infected with HIV through MSM contact only (**71.3%** of all PLWHA) and **2,599** MSM who also injected drugs (**14.2%** of all PLWHA). This represents an **increase** from the end of 2008, when MSM made up **82.3%** of all PLWHA. By comparison, only **36.2%** of PLWHA in New York City as of December 31, 2012 were listed as infected through MSM contact.[9] Factors underlying this difference include the high proportion of gay and bisexual men living in the EMA, particularly in the city of San Francisco; the large number of long-term MSM HIV survivors; growing rates of STD infection among MSM; and relatively high local drug use rates. **A startling 31.2% of all gay-identified MSM in the San Francisco EMA may already be HIV-infected, setting the stage for a continuing health crisis that will impact the future of our region for decades to come.** By contrast, less than **0.4%** of heterosexual men are estimated to be HIV-infected in the San Francisco EMA.

Additionally, a large and rapidly growing proportion of persons living with HIV and AIDS in our region are **persons age 50 and above.** This is attributable both to the long history of the HIV/AIDS epidemic in our EMA - resulting in a large proportion of long-term survivors - and to the region's hard-fought success in bringing persons with HIV into care and prolonging the length of their lives. As of December 31, 2013, for the first time, **more than half** of all persons living with HIV/AIDS in the EMA (**51.8%**) are age 50 or older, including **1,269** PLWHA age 65 or older. This represents a startling increase of **31.1%** in the number of PLWHA 50 and older living in the EMA since December 2006. At the same time, persons 50 and older also now make up nearly **3 out of every 5 persons living with AIDS in our EMA,** constituting **59.0%** of the region's PLWA population (n=**6,906**)**.** This growing aging population creates dramatic challenges for the local HIV service system, including the need to develop systems to coordinate and integrate HIV and geriatric care and to plan for long-term impacts of HIV drug therapies.

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 **13.3%** of the combined PLWHA population in the San Francisco EMA. This means that **more than three times** the percentage of African Americans are infected with HIV as their proportion in the general population. And while **59.9%** 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 **5.7%** of PLWHA cases while Latinos constitute **18.5%** of PLWHA but make up **19.3%** of EMA residents. However, new HIV cases will soon create a disproportionate impact among both Asian and Latinos populations, with PLWH increases of **12.7%** among Pacific Islanders and **6.4%** among Latinos over the two-year period between December 31, 2011 and December 31, 2013 alone.

Homeless and **formerly incarcerated individuals** are also disproportionately impacted by HIV 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,[10] the combined annual EMA-Wide homelessness rate among persons living with HIV and AIDS is estimated at **7,999** per 100,000[11] - a rate **more than four times** the rate of homeless among the general population. Meanwhile, according to the Center on Juvenile and Criminal Justice, a total of **18,857** EMA residents were imprisoned at some point during calendar year 2011,[12] while more than **43,000** annual bookings take place in the three-county region.[13] 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.

Underrepresented Populations in the Ryan White System: The chart below compares the population of PLWHA enrolled in the San Francisco EMA Ryan White system of care for FY 2013-2014 with the EMA's combined PLWHA population as of 12/31/13 (see **Figure 4**)

Figure 4. Comparison of San Francisco EMA Ryan White Clients with Overall PLWHA Population

Demographic Group / Exposure Category	Total Unduplicated Clients Enrolled in Ryan White Services - 3/1/13 - 2/28/14		Combined SF EMA PLWHA Population as of 12/31/13		Population Variances
Race/Ethnicity					
African American	1420	20.5%	2433	13.3%	+ 7.3%
Latino / Hispanic	1668	24.1%	3388	18.5%	+ 5.6%
Asian / Pacific Islander	379	5.5%	1054	5.7%	- 0.3%

Demographic Group / Exposure Category	Total Unduplicated Clients Enrolled in Ryan White Services - 3/1/13 - 2/28/14		Combined SF EMA PLWHA Population as of 12/31/13		Population Variances
White (not Hispanic)	3052	44.1%	10986	59.9%	- 15.8%
Other / Multiethnic / Unknown	396	5.7%	471	2.6%	+ 3.2%
	6915	**100%**	**18332**	**100%**	
Gender					
Female	789	11.4%	1209	6.6%	+ 4.8%
Male	5915	85.5%	16727	91.2%	- 5.7%
Transgender	211	3.1%	396	2.2%	+ 0.9%
	6915	**100%**	**18332**	**100%**	
Age					
0 - 24 Years	139	2.0%	222	1.2%	+ 0.8%
25 - 44 Years	2143	31.0%	5860	32.0%	- 1.0%
45 - 54 Years	2536	36.7%	6863	37.4%	- 0.8%
55 - 64 Years	1658	24.0%	4118	22.5%	+ 1.5%
65 Years and Above	439	6.3%	1269	6.9%	- 0.6%
	6915	**100%**	**18332**	**100%**	
Transmission Categories					
MSM	3914	56.6%	13071	71.3%	- 14.7%
Injection Drug Users	748	10.8%	1294	7.1%	+ 3.8%
MSM Who Inject Drugs	655	9.5%	2599	14.2%	- 4.7%
Heterosexuals	418	6.0%	793	4.3%	+ 1.7%
Other	211	3.1%	81	0.4%	+ 2.6%
Unknown	969	14.0%	494	2.7%	+ 11.3%
TOTAL	**6915**	**100%**	**18332**	**100%**	

Compared to their proportion of HIV/AIDS cases, **women, persons of color, heterosexuals,** and **transgender people** are **over-represented** in the local Ryan White-funded system, Meanwhile, **whites, men,** and **MSM** are **underrepresented** due largely to higher average incomes and higher rates of private insurance which reduce their need to rely on Ryan White-funded care. For example, while women make up only **6.6%** of all PLWHA in the EMA, they comprise **11.4%** of all Ryan White clients as of February 28, 2014 (n=**1,209**). Meanwhile, while whites make up **59.9%** of all PLWHA in the EMA, they comprise only **44.1%** of Ryan White clients as of the same date (n=**3,054**). Ryan White clinics provide primary medical care to a population that is disproportionately made up of persons of color, women, persons with low incomes, the homeless, heterosexuals, and injection drug users. Additionally, local Part D programs primarily serve young people and women, while Part C programs such as those operated by the San Francisco Clinic Consortium serve the full spectrum of clients, including the homeless, persons of color, women, and gay/bisexual men. Fully **20.5%** of Ryan White clients in the San Francisco EMA are African American (n=**1,420**) despite the fact that they comprise **13.3%** of all persons with HIV/AIDS in the EMA. At the same time, San Francisco's seven **Centers of Excellence** which focus on underserved and hard-to-reach populations serve a population that is **30.6%** African American.[14] Women, representing **6.5%** of the total PLWHA

population, make up **21.7%** of all Centers of Excellence clients. Transgendered people make up **3.0%** of persons served through the Ryan White system and **5.4%** of persons served through Centers of Excellence while making up **2.1%** of all persons living with HIV and AIDS in the EMA. **All of these statistics highlight the progress the San Francisco EMA has made in reaching and bringing into consistent care the most impoverished and highly underserved HIV-infected residents of the region.**

New and Emerging Populations Not Reported in Previous Year's Application: No new or emerging populations not previously identified have been identified during the most recent 12-month epidemiological reporting period.

2.A) UNMET NEED

2.A.1) Unmet Need Framework - See **Table** in **Attachment 4**

2.A.2) Changes in Unmet Need Percentage - See **Figure 5**

Figure 5.
Reported Percentages of Unmet Need in San Francisco EMA – FY 2011 - FY 2013

FY 2010-2011	FY 2011-2012	FY 2012-2013
11%	12%	13%

The table above shows the percentage of unmet need in San Francisco for fiscal years 2011–2013, based on calculations made for a July 1 – June 30th cycle for each year and reported in each year's Ryan White Part A application. The table shows a slight annual increase in the percentage of persons with unmet need in the EMA between FY 2011 and FY 2012, following a decrease between FY 2010 and FY 2011. This change is believed to be due to more complete HIV surveillance reporting, which allows our EMA to capture more PLWH not regularly receiving care who were unreported in previous years.

2.A.3) 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, 2012 through June 30, 2013 we estimated these populations across **four** critical categories: HIV/AIDS status, gender, race/ethnicity, and age group – results that are reported in **Figure 6** 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.

Figure 6. San Francisco EMA Demographic Analysis of People in and Out of Care July 1, 2012 through June 30, 2013: ALL Persons Living with HIV or AIDS (PLWHA)*

Characteristic	#1: PLWHA Population	#2: Number with Met Need	#3: Number with Unmet Need	#4: % of Unmet Need Population**	#5: % of Category with Unmet Need**	#6: % of Total PLWHA Population**
All PLWHA	21,339	18,573	2,766	100.0%	13.3%	100.0%
HIV/AIDS Status						
PLWA	12,890	11,679	1,151	41.6%	9.2%	60.3%
PLWH / no AIDS	8,449	6,894	1,615	58.4%	19.6%	39.7%
Gender at Birth						
Male	19,748	17,175	2,575	93.1%	13.4%	92.5%
Female	1,591	1,398	191	6.9%	12.3%	7.5%
Race/Ethnicity:						
White	12,718	11,108	1,606	58.1%	13.0%	59.6%
African American	2,923	2,521	405	14.6%	14,2%	13.7%
Latino	3,955	3,462	491	17.7%	12.7%	18.5%
Asian/PI	1,190	1,023	168	6.1%	14,5%	5.6%
Other	554	460	96	3.5%	17.8%	2.6%
Age in Years*:						
0-19	55	43	13	0.5%	24.6%	0.3%
20-29	1,073	864	214	7.8%	20.5%	5.0%
30-39	3,108	2,534	589	21.3%	19.5%	14.6%
40-49	7,629	6,611	1,020	36.9%	13.7%	35.8%
50-59	6,585	5,907	662	23.9%	10.3%	30.9%
60 or older	2,889	2,614	266	9.6%	9.5%	13.5%

* Age at the beginning of the time period.

** Column calculations: Column #4 = Column #3 / total with unmet need (n=2,502); Column #5 = Column #3 / Column #1; Column #6 = Column #1 / total number PLWHA (n=20,791)

Trends Associated with the Past Three Years Regarding Unmet Need: **Figure** 4 above lists percentage of unmet need in San Francisco for July 1, 2010 - June 30, 2013, and demonstrates a steady through gradually increasing percentage of persons with an unmet need for HIV primary medical care in the San Francisco EMA, from **11%** in FY 2011 to **11%** in FY 2012 to **13 %** in FY 2013. As noted above, the decrease in unmet need is believed to be largely due to more complete HIV surveillance reporting, which allows our EMA to capture more PLWH not regularly receiving care who were unreported in previous years. 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 four 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 **58%** of the unmet need population this year (n=**1,615**). At the same time, while the percentage of out-of-care PLWA has increased from **30%** to **42%,** the actual number of out-of-care PLWA has shown only a slight increase over the same two-year period, from **1,115** to **1,151**. Few other significant demographic changes in the out-of-care population have occurred over the past two years, with the exception of an increase in the percentage of out-of-care Latinos from **16%** to **18%**.

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 other findings led to strengthened funding request for Centers of Excellence programs specifically directed toward **African Americans** and **women**, while work in collaboration with local CoEs was strengthened to extend outreach efforts to out-of-care populations while continuing to support Treatment Adherence to help complex populations remain in care.

How Results of the Unmet Need Framework are Reflected in Planning and Decision Making in the SF EMA: Results of the Unmet Needs Framework analysis are presented to the San Francisco HIV Health Services Planning Council during the prioritization and allocation process and play a critical role in helping influence and shape both service category and funding decisions. Findings related to unmet need among ethnic minority populations, for example, have helped to reinforce the approach of funding Centers of Excellence that create centralized service structures for severe need and hard-to-reach populations, particularly Latinos and African Americans. Findings related to unmet need among young people have influenced decisions to continue prioritizing substance abuse services to address chemical addiction barriers that can limit young people's ability to access HIV testing and care. The Unmet Needs Framework is an important document through which the Planning Council determines how best to allocate

resources to bring more persons with HIV into care and to create service responses that meet the needs of expanding populations.

2. B) Early Identification of Individuals with HIV/AIDS (EIIHA)

2.B.1) EIIHA Data

Chart A. San Francisco EMA Newly Diagnosed HIV Test Events January 1 - June 30, 2014			
Data Elements	**MSM**	**IDU**	**MTF/M**
▪ Number of test events	**9720**	**548**	**482**
▪ Number of newly diagnosed positive test events	**113**	**3**	**9**
▪ Number of newly diagnosed positive test events with clients with reported linkage to medical care	**66***	**1***	**3* Incomplete linkage data**
▪ Number of newly diagnosed confirmed positive test events	**108**	**2**	**9**
▪ Number of newly diagnosed confirmed positive test events with client interviewed for Partner Services	**106**	**2**	**9**
▪ Number of newly diagnosed confirmed positive test events with clients referred to prevention services	**108**	**2**	**9**
▪ Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing	**66***	**1***	**3***

Chart B. San Francisco EMA Previously Diagnosed HIV Test Events January 1 - June 30, 2014			
Data Elements	**MSM**	**IDU**	**MTF/M**
▪ Number of test events	**9720**	**548**	**482**

Chart B. San Francisco EMA Previously Diagnosed HIV Test Events January 1 - June 30, 2014			
Data Elements	**MSM**	**IDU**	**MTF/M**
▪ Number of previously diagnosed positive test events	**11**	**0**	**0**
▪ Number of previously diagnosed positive test events with clients with reported re-engagement in HIV medical care	**7**	**0**	**0**
▪ Number of previously diagnosed confirmed positive test events	**10**	**0**	**0**
▪ Number of previously diagnosed confirmed positive test events with client interviewed for Partner Services	**7**	**0**	**0**
▪ Number of previously diagnosed confirmed positive test events with clients referred to prevention services	**3**	**0**	**0**
▪ Number of previously diagnosed confirmed positive test events liked to and accessed CD4 cell count and viral load testing	**7**	**0**	**0**

2.B.2) FY 2015 EIIHA Plan

2.B.2.a) Planned Activities of the San Francisco EMA EIIHA Plan for FY 2015

Estimate of HIV-Positive Individuals Who Are Unaware of Their Serostatus: The San Francisco EMA has solid indications that it has achieved significant success in reducing the number of persons with HIV in the EMA who are unaware of their serostatus. As recently as our last Part A application, the EMA estimated that a total of approximately **3,339** individuals were infected with HIV but unaware of their serostatus as of the end of 2012, representing **14.4%** of all persons currently estimated to be infected with HIV in our region. This estimate - still lower than the CDC's 2013 estimate of **18%** HIV-infected unaware nationally - was derived by calculating a proportion of persons with AIDS to persons with HIV of **1:1** based on consensus epidemiological meetings conducted in San Francisco in 2012. **However, the EMA's aggressive engagement approach, combined with rapid implementation of new scientific advances, have now led to the lowest rate of undiagnosed HIV infection in the country, currently estimated at only 6.4%, with viral load suppression rates that far surpass the national average (68% in SF vs. 25% nationally).**[15] This would mean that only **1,173** HIV-infected and unaware persons

were living in the San Francisco EMA as of December 31, 2013. As expressed in a recent article in the *Journal of Acquired Immune Deficiency Syndrome„* *“*“Treatment as prevention’ may be occurring in San Francisco”.[16]

Target Populations for FY 2015 EIIHA Plan: To define and focus EIIHA activities, the following **three** populations will continue to serve as the key target groups for the FY 2015 San Francisco EMA EIIHA Plan:

1. **Males Who Have Sex with Males (MSM)**
2. **Injection Drug Users (IDU)**
3. **Transgender Females Who Have Sex with Males (TGF/M)**

Primary Activities to be Undertaken: The FY 2015 EIIHA Plan will encompass **two** broad activity areas which mirror those of the FY 2013 and FY 2014 Plans. The first of these areas involves continuing to identify individuals who are unaware of their HIV status and providing high-quality rapid antibody testing and acute RNA pooled screening for most MSM. San Francisco is in the process of implementing so-called “rapid 4th generation” combination antibody / antigen (Ab/Ag) tests which differ from previously developed screening technologies by identifying not only HIV antibodies but also HIV-1 p24 antigens, which in turn allows for the identification and rapid treatment of acute HIV-1infection. All other existing HIV screening technologies have window periods exceeding the acute infection period, which may result in false negative tests in acutely-infected patients, and in turn miss not only an HIV diagnosis but the opportunity to intervene with treatment and counseling at the time when an individual is most likely to pass his or her HIV infection on to others. Additionally, the new 4th generation HIV Ab/Ag combination assays are extremely fast, and can be processed in as few as **29 minutes**, making them extremely practical for use in virtually all opt-out testing settings. San Francisco has applied for and is in the process of obtaining a CLIA waiver for the use for the rapid 4th generation test. Once the waiver is received, the EMA will begin to convert **all** publicly funded HIV testing to this method, while continuing pooled RNA testing on high risk populations.

The second key activity area involves ensuring that HIV-positive individuals are successfully linked to essential medical and social services based on individual need. Specific activities to be undertaken through the Plan will be tailored to meet the needs of its three identified target population groups, with a particular emphasis on continuing to enhance systems to link newly identified HIV-positive individuals to care and to support them in remaining in care as they transition into acceptance of their HIV status.

Major Collaborations: As sister units in the San Francisco Department of Public Health AIDS Office, HIV Health Services works in close partnership with the Community Health Equity and Promotion Branch to plan services, design interventions, and share data and emerging findings. The Disease Control and Prevention Branch, which oversees the LINCS program, is also a key collaborator. Through a strong working relationship, the three units are able to closely coordinate prevention and care planning and interventions with the goal of maximizing available resources and ensuring a seamless testing system in the EMA. The collaboration also aims to ensure non-duplication and non-supplantation of Ryan White Program funding. The collaboration is augmented by strong working relationships

involving virtually all providers of HIV-specific prevention and care services in the EMA, as well as agencies serving high-prevalence populations at risk for HIV infection.

The two San Francisco County agencies and a broad range of related programs and services in the EMA operate through the region's **Continuum of HIV Prevention, Care, and Treatment** - a model developed through the Enhanced Comprehensive HIV Prevention Plan (ECHPP) process and continued as part of core HIV prevention funding from CDC. The Continuum specifically focuses on **HIV testing, partner services, linkage, retention, re-engagement, and treatment adherence** and supports entry into and retention in care through sectors such as mental health services, substance abuse treatment, housing support, and medical case management. The model also incorporates the Department's **Linkage Integration Navigation Comprehensive Services (LINCS) Program**, an innovative approach to care linkage and retention involving teams that work one-on-one with newly identified or out-of-care clients that ensure effective linkage to engagement in care.

Although not required by HRSA, in San Francisco, the HIV Health Services Planning Council is charged with coordinating both Part A and B and services to maximize the impact of these two funding streams. This service planning process is in turn coordinated with all units of the former San Francisco AIDS Office, including the Community Health Equity and Promotion and the Disease Prevention and Control Branches, in order to enhance regional efforts to identify and link to care persons with HIV who are unaware of their positive status. At the same time, representatives of agencies receiving funds through Ryan White Parts C, D, and F play an active role on the Planning Council to ensure integration and coordination of EIIHA activities with other Ryan White-funded services.

The San Francisco EMA EIIHA system is designed to ensure that **any** door is the right door to HIV testing and treatment and that potential clients are able to access HIV services from any point in the EMA's health and social service network. To accomplish this outcome, the EMA has created extensive service partnerships and collaborations with providers across our region that are designed to link and integrate HIV prevention and care, and to create effective data and referral interfaces among public and private providers which enhance information-sharing and communication. The EMA has also strongly emphasized the need to work toward linking and merging the concepts of prevention and care and to eliminate arbitrary distinctions that can serve as barriers to planning and resource sharing and can unintentionally act as barriers to client entry into care. To ensure a fully linked and coordinated system, planning meetings are held throughout the EMA involving the broadest possible range of provider groups to plan and develop systems for strengthening mutual information-sharing, support, and client linkage programs. A number of community planning bodies that incorporate extensive consumer participation – including the San Francisco HIV Health Services Planning Council and HIV Prevention Planning Council – help develop and enhance HIV access across systems, while ensuring that consumer voices and perspectives are incorporated into systemic and policy decisions. Meanwhile, County agencies are engaged in extensive provider outreach and education efforts designed to bring a greater level of participation, cooperation, and quality monitoring to the HIV programs of non-publicly funded organizations and entities.

Planned Outcomes of FY 2015 EIIHA Plan: The FY 2015 San Francisco EMA EIIHA Plan has **three** primary goals: 1) to increase the number of individuals in Marin, San Francisco, and San Mateo counties who are aware of their HIV status; b) to increase the

number of HIV-positive individuals in our region who are effectively engaged in HIV care; and c) to reduce disparities in regard to both HIV infection and HIV testing access. Specific objectives and activities through which progress toward these goals will be measured are described in greater detail in the population-specific section below.

It is important to stress the fact that one of the most important aspects of HRSA's EIIHA initiative lies in its potential to significantly **reduce disparities** in HIV access and services for underserved HIV-infected populations. This is an outcome which mirrors one of the three central goals in the National HIV/AIDS Strategy for the US, which involves reducing HIV-related health disparities. By incorporating routine HIV testing in medical settings where under-served populations are seen, the EIIHA plan will reach many individuals who would not otherwise voluntarily seek or be offered HIV testing, including MSM of color, substance users, women, uninsured and economically impoverished populations, homeless persons, and young MSM – all populations that have experienced historical HIV access and treatment disparities along with high rates of late HIV testing. The San Francisco EMA will utilize its EIIHA plan and matrix to focus on increasing awareness of HIV status and promoting treatment utilization among underserved populations as a way to continue to address HIV-related health disparities.

2.B.2.b) How the FY 2015 Plan Contributes to the Goals of the National HIV/AIDS Strategy: The goals and objectives of the proposed FY 2015 EIIHA Plan continue to be fully consistent with and contribute to the goals of the White House Office of AIDS Policy's National HIV/AIDS Strategy, including the Strategy's three primary goals of: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.[17] Our local EIIHA strategy is also fully consistent with HRSA's goal of making unaware individuals aware of their HIV status, particularly in terms of the strategy's aggressive approach to reaching and testing highly impacted HIV populations in the San Francisco EMA.

2.B.2.c) Relationship to Unmet Need Estimate and Activities: The FY 2015 EIIHA Plan responds to the EMA's annual unmet need process both prospectively and retrospectively. In a prospective sense, the EIIHA Plan seeks to significantly decrease the number of persons living with HIV/AIDS in the region who are unaware of their HIV status. This is particularly critical at a time when health care reform is creating new options for increasing the number of low-income persons with HIV who are able to access affordable, high-quality health care coverage. Retrospectively, the EIIHA Plan utilizes unmet needs data to prioritize specific target populations on which to focus regional outreach, testing, and care linkage and retention activities and resources.

2.B.2.d) How the FY 2014 EIIHA Plan Influenced the FY 2015 Plan: A key facet of our EIIHA plan is that it is **highly flexible** in order to incorporate new prevention advances and community input and engagement in real time. In addition, HIV testing and linkage models identified in the 2014 Plan have proved successful in reducing undiagnosed infection and improving linkage to care, so these models will continue. The EMA is examining emerging interventions to enhance early intervention including pre-exposure prophylaxis (PrEP), same day linkage to care, and widespread use of rapid 4th generation rapid antigen /antibody testing.

2.B.2.e) Planned Efforts to Remove Legal Barriers: Opt-out testing is now routine in our EMA with no barriers. Most existing barriers are related to cross-jurisdictional issues

related to linkage and partner services and the legal parameters of sharing patient data. As these issues are resolved, our ability to track, monitor, and enhance testing and care across our three counties will increase dramatically.

2.B.2.f) FY 2015 Target Populations: As noted above our three EIIHA target populations for FY 2015 are: 1) Males Who Have Sex with Males (MSM); 2) Injection Drug Users (IDU); and 3) Transgender Females Who Have Sex with Males (TGF/M).

Why Target Populations Were Chosen: The three FY 2015 target populations were selected on the basis of **three** key factors. **First**, from an epidemiological standpoint, these three populations together encompass approximately **95%** of all persons currently living with HIV/AIDS in the San Francisco EMA. MSM alone - including MSM who inject drugs - alone make up **85.5%** of all HIV/AIDS cases in the region as of December 31, 2013, while non-MSM IDU make up another **71.%** of all local PLWHA. **Second**, the populations represent the three groups most highly prioritized in the EMA's recent Jurisdictional HIV Prevention Plans, which represent the product of intense study and collaborative planning. And **third**, the selected populations contain the highest rates of new HIV diagnoses as reported through HIV testing data for the period January 1 - June 30, 2015 (see testing table above).

Specific Challenges within the Target Populations: With the emergence of a new prevention paradigm in which broadly based viral load suppression holds out the possibility of dramatically reduced rates of new HIV infections, additional challenges emerge that are equally salient. What standardized models of routine HIV testing are most appropriate for which health care settings, and what are the cost and capacity factors associated with these approaches? The current recommendation is for low-risk individuals to receive one HIV test in a lifetime. Challenges to operationalizing this include the question of whether to test that one time at, say, 18 years of age or 64 years of age. While the recommendation was a helpful start it needs more structure of guidance for full implementation.

A further challenge involves the question of how the San Francisco EMA can best encourage regular, ongoing HIV testing among members of high prevalence populations, particularly when a negative test can sometimes be perceived as an indication that the individual is managing risk effectively. Put another way, how is it possible to create a cultural norm of HIV test every 3 to 6 months with highest risk populations? Additional questions include: How will our ability to detect acute HIV more systematically as new technologies emerge, combined with the local SFDPH universal offer of ARV treatment independent of HIV disease stage, impact system capacity? And as more persons with HIV are identified, how can we ensure that these individuals are linked to care and do not fall through the cracks, particularly in a climate of diminishing resources? What are the long-term cost and capacity issues associated with bringing an expanded population into HIV care, particularly in light of the decades of medical and drug treatment support most of these individuals are likely to need? While the potential benefits of expanded HIV testing and care linkage are great, the challenges faced by systems and providers may prove to be commensurately daunting.

The San Francisco EMA had remarkable success in removing barriers to status awareness. Yet the following challenges do remain a) continuing widespread stigma related to both HIV infection and the behaviors that can transmit the virus; b) fear of having HIV status or behaviors exposed by service providers, including sexual and drug use behaviors;

c) fear among transgender persons of negative interactions between hormone therapies and HIV medications; and d) fear of deportation among undocumented immigrants, e) in some case active substance use can hinder able ability to access testing A challenges particular to San Mateo and Marin Counties involves the lack of access to MSM due to the fact there are no gay specify venues or hangouts.

Key **cultural issues** impacting HIV awareness in San Francisco include: a) dual discrimination faced by many MSM of color in regard to sexual orientation and ethnic background; b) threefold discrimination faced by many transgender persons of color in regard to gender identity, sexual orientation, and ethnic background; c) fear and mistrust regarding HIV drug treatment and the medical care system within communities of color; d) fear that HIV risk behaviors or sexual or gender orientation will be judged or stigmatized in culturally specific are and service systems; e) fear of discrimination based on ethnicity within HIV service agencies; f) shortage of culturally specific drug treatment programs for persons of color; and g) lack of programs that effectively address key issues underlying HIV risk behaviors and an unwillingness to seek testing such as persistent poverty, institutionalized discrimination, and childhood abuse and exposure to trauma.

Specific Activities to be Utilized With the Target Populations: The San Francisco EMA will employ a broad range of strategies to expand awareness of, access to, and utilization of HIV testing and care services in the service region, but for persons who are currently unaware of their HIV status and for persons with HIV who have dropped out of or become lost to care. The table beginning on the following page outlines these activities in relation to the three FY 2015 target populations. All activities listed in the EIIHA Plan will be coordinated with activities conducted by the HIV prevention units in the three EMA counties as outlined in the integrated jurisdictional HIV Prevention Plans. All activities will also be coordinated with the ongoing ECHPP process to promote HIV prevention and care integration in the region.

In addition to the activities listed on the chart below, San Francisco will also continue implementation of care access enhancement activities being made possible through the Center for Medicaid and CHIP Services **Delivery System Reform Incentive Pool (DSRIP)** and its **Category V** program specifically designed to enhance the capacity of participating hospitals to develop programs to provide access to high-quality, coordinated, integrated care to patients diagnosed with HIV, particularly Low Income Health program (LIHP) enrollees who previously received services through Ryan White funding. The San Francisco DSRIP Category V program is being implemented at San Francisco General Hospital and is creating a range of specific HIV care enhancements, many of which are expected to expand the quality of care linkage and retention services in the region. This includes creation of a **model retention program** within patient-centered medical homes for persons with HIV, which began in April 2013 with a pilot program at San Francisco General Hospital for patients with high rates of missed primary care appointments as part of the ongoing PHAST program. The DSRIP pilot project aims to take best practices developed under the PHAST program that serves approximately **500** patients at high risk for non-linkage to care and apply them to the **3,000** patients followed in the hospital's HIV-specific Ward 86 clinic, with the goal of developing interventions to improve patient show rates for HIV primary care appointments. Through the DSRIP Category V program, extensive staff training programs are also being held throughout the hospital system to ensure care coordination within each medical clinic designated as a medical home for patients with HIV.

SMART Objectives for Each Target Population:

MSM:

1. Between March 1, 2015 and February 28, 2016, to provide a total of at least **19.000** documented HIV antibody tests for MSM in the San Francisco EMA.
2. Between March 1, 2015 and February 28, 2016, to identify a total of at least **190** new HIV-positive individuals within this population.
3. Between March 1, 2015 and February 28, 2016, to identify a total of at least **100** previously diagnosed HIV-positive individuals within this population.
4. Between March 1, 2015 and February 28, 2016, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
5. Between March 1, 2015 and February 28, 2016, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
6. Between March 1, 2015 and February 28, 2016, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
7. Between March 1, 2015 and February 28, 2016, ensure that at least **75%** accept partner services.

IDU:

8. Between March 1, 2015 and February 28, 2016, to provide a total of at least **1,750** documented HIV antibody tests for IDU in the San Francisco EMA.
9. Between March 1, 2015 and February 28, 2016, to identify a total of at least **20** new HIV-positive individuals within this population.
10. Between March 1, 2015 and February 28, 2016, to identify a total of at least **15** previously diagnosed HIV-positive individuals within this population.
11. Between March 1, 2015 and February 28, 2016, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
12. Between March 1, 2015 and February 28, 2016, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
13. Between March 1, 2015 and February 28, 2016, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
14. Between March 1, 2015 and February 28, 2016, ensure that at least **75%** accept partner services.

Transgender Women Who Have Sex with Men:

15. Between March 1, 2015 and February 28, 2016, to provide a total of at least **480** documented HIV antibody tests for transgender women who have sex with men in the San Francisco EMA.
16. Between March 1, 2015 and February 28, 2016, to identify a total of at least **5** new HIV-positive individuals within this population.
17. Between March 1, 2015 and February 28, 2016, to identify a total of at least **6** previously diagnosed HIV-positive individuals within this population.
18. Between March 1, 2015 and February 28, 2016, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
19. Between March 1, 2015 and February 28, 2016, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
20. Between March 1, 2015 and February 28, 2016, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and

21. Between March 1, 2015 and February 28, 2016, ensure that at least **75%** accept partner services.

Responsible Parties and Collaborations: Implementation and evaluation of the FY 2015 EIIHA Plan will be the joint responsibility of San Francisco HIV Health Services, the San Francisco Community Health Equity and Promotion Brach, and the San Francisco Disease Prevention and Control Branch, with the close collaboration of the San Francisco care and prevention planning bodies and prevention and care staff in Marin and San Mateo Counties. County staff will continually collect data related to HIV testing, service linkage, and other follow-up activities for each of the target populations and will regularly report this information to the State of California and will summarize the data in regular reports to HRSA as required. Additionally, the EMA's three counties will collect information on specific enhancements and service activities brought about through the EIIHA Plan and will report these activities to HRSA as required. Modifications to the EIIHA Plan made during the 2015 Part A fiscal year will be jointly approved by the three counties and discussed and approved by the EMA's prevention and care councils.

Planned Outcomes: The proposed FY 2015 EIIHA strategy will continue the work of the San Francisco EMA to expand and enhance awareness and utilization of HIV testing throughout the region for the project's three key populations, while increasing utilization of care and prevention services and promoting greater adherence to HIV treatment services.

2.B.2.g) Plan to Disseminate EIIHA Plan and Outcomes: As a document jointly developed by HIV Health Services and the Community Health Equity & Promotion Branch, the FY 2015 EIIHA Plan will be shared with both the San Francisco Health Services Planning Council - the Ryan White Part A oversight body - and the San Francisco HIV Prevention Planning Council. The EIIHA Plan will also be shared with prevention staff of both Marin and San Mateo counties. Ongoing progress related to EIIHA action steps will be extensively reported to the Planning Council and the Prevention Council with the goal of refining and helping shape future EIIHA action plans and strategies. Model interventions and programs developed through the EIIHA program will be broadly disseminated and shared among public and private providers throughout the San Francisco EMA, including through trainings developed and presented to community-based HIV providers and public and private medical providers. The San Francisco EMA may also publish best practice documents or guidelines related to specific aspects of the outreach, testing, and linkage enhancement initiative, and/or develop and conduct trainings for local agencies and staff on demonstrated methods for enhanced EIIHA-related planning and program implementation.

2.C) Unique Service Delivery Challenges: Despite implementation of the Affordable Care Act (ACA), the San Francisco EMA HIV system of care - a system that has served for decades as a national model of effective HIV service delivery - continues to face challenges that threaten both the quality and availability of care for persons with HIV/AIDS in the region. These challenges stem from a convergence of factors which 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

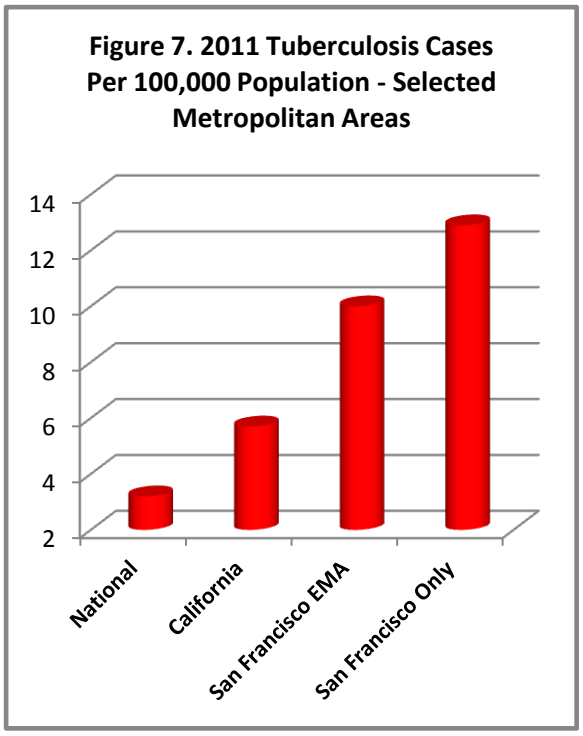
and AIDS cases within a relatively small geographic area, especially in the case of San Francisco. Each of these issues - described briefly below - places a particular burden on the system of care, and presents challenges to a Planning Council struggling to maintain an adequate level of support for **all** impoverished persons with HIV.

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 **55%** over the last 13 years alone. **This crisis requires increased resources, not reduced ones.** The **18,332** persons living with diagnosed HIV and AIDS as of 12/31/13 represents **54.3%** of the total 33,761 AIDS cases **ever diagnosed** in the San Francisco EMA, and is **nearly 80%** of the 22,978 people who had **ever died** from AIDS in the region through mid-2014. 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 HIV and 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;[18] nearly **one in ten** persons newly diagnosed with AIDS in the EMA is homeless;[19] as many as **half** of MSM living with HIV in the EMA suffer from depression;[20] **thirty percent** of local PLWHA are active substance users;[21] **one in seven** persons with HIV in the EMA speaks a primary language other than English;[22] **as many as one-third** of gay-identified men in the San Francisco EMA may be HIV-infected;[23] 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.[24]

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. The most 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.[25]



Escalating Co-Morbidities: Section 3.C 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 growing local epidemic of **hepatitis C**, for example, remains a significant concern. 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.[26] Existing hepatitis C treatments are also costly, and are effective for only about **50%** of people who take them. A single 48-week treatment course of injected interferon and oral ribavarin costs more than **$20,000.**[27] 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.**[28] **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 **178** new cases of TB diagnosed in the SF Metropolitan Area in 2012, representing an EMA-wide incidence of **10.0** cases per 100,000.[29] In San Francisco, the incidence is even higher, at **12.9** cases per 100,000. San Francisco County's 2013 TB rate ranked **second** in California out of 58 counties, while San Mateo ranked **sixth** and Marin County ranked 15th. **San Francisco's TB incidence rate is more than double than the statewide rate of 5.7 cases per 100,000 and nearly four times higher than the national rate of 3.2 cases per 100,000** (see **Figure 7**).[30] 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.[31]

The problem of **poverty** presents another daunting challenge to the HIV care system. According to the 2010 Census, the average percentage of persons living at or below federal poverty level stands at **9.2%** for the entire San Francisco EMA. Using this data, SF DPH projects that at least **490,201** individuals in the San Francisco EMA are living at or below

300% of Federal Poverty Level, which translates to **27.6%** of the overall EMA population lacking resources to cover all but the most basic expenses. **However, because of the high cost of living in the San Francisco Bay Area, persons at 300% of poverty or below have a much more difficult time surviving in our area than those living at these income levels in other parts of the U.S.** Analyzing data from the San Francisco AIDS Regional Information and Evaluation System (ARIES),the SF EMA's client-level data system, it is estimated that at least **68.9%** of all persons living with HIV/ AIDS in the San Francisco EMA (n=**12,631**) are living at or below 300% of the 2013 Federal Poverty Level (FPL) including persons in impoverished households. **100%** of Ryan White-funded clients live at or below 300% of poverty.[32] ARIES data reveals that as of the end of February 2014, **59.7%** of active Ryan White clients in the San Francisco are currently living at or below 100% of FPL while another **29.4%** are living between 101% and 200% of FPL. HIV-infected persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **$69 million** in Part A and non-Part A HIV-related expenditures in the San Francisco EMA each year.[33]

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 one or two people will have HIV. As noted above, **1 in every 50** 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.

2.D) Minority AIDS Initiative

2.D.1) Targeted MAI Populations: The San Francisco EMA utilizes Part A MAI funds specifically to support services for **low-income HIV-infected Latino and Latino populations.** While some service dollars incidentally support other populations of color with HIV, local MAI funds are almost exclusively focused on ensuring culturally and linguistically appropriate services to this large and rapidly growing PLWHA population.
2.D.2) Consideration of MAI Funds During Planning Process: As part of its annual prioritization and allocations process, the Planning Council receives a comprehensive summary of the specific services currently funded through Minority AIDS Initiative funding, and incorporates decision-making regarding MAI allocations into its overall FY 2015 allocations process. The MAI summary details specific goals of the local MAI process; historical funding levels received in the region; previous and current expenditures with that funding; specific outcomes achieved in regard to minority health, health access, and

service utilization; and provides a quantified report on the demographics of populations served through MAI funding. This year's report validated the success of the EMA's approach to MAI allocations, and affirmed the key role that MAI funding plays in helping reduce HIV disparities while meeting the needs of historically underserved populations.
2.D.3) Description of MAI-Funded Activities: Minority AIDS Initiative funds have had a major impact on the San Francisco EMA, allowing us to identify, reach, and bring into care a significant number of highly disadvantaged persons of color, in turn reducing service disparities and improving health outcomes across the region. FY 2013-2014 Part A MAI funding has enabled the EMA to serve **over 400** impoverished clients of color, many of whom are transgender people. The primary manner in which MAI funds ensure quality care access for communities of color is through funding of the **Mission Center of Excellence** that has been established in the heavily Latino Mission district by **Mission Neighborhood Health Center.** The Mission CoE addresses what is both the fastest growing and one of the most highly impoverished communities in San Francisco in terms of HIV infection. Between 2011 and 2013 alone, Latino/a PLWHA in the EMA grew from **15.5%** to **18.5%** of total PLWHA, while Latinos represented **19.1%** of all new non-AIDS HIV cases identified in calendar year 2013. According to the Pew Research Center, **29%** of Hispanics in California lack any form of health insurance and **25%** of Hispanics 17 and under live below the Federal Poverty Line.[34] The **Mission Center of Excellence** provides culturally competent, integrated, bilingual/bi-cultural medical and health services to community members living with HIV, with an emphasis on Spanish-speaking Latino clients. In addition to supporting the cost of direct medical / ambulatory health services through a staff of five bilingual / bicultural professionals, MAI funding also helps support the cost of medical case management, psychiatric, treatment adherence, and mental health services. MAI-funded peer and treatment advocates also help clients make informed decisions about medications, and work with them to identify and remove barriers to adherence.

3) Impact of Funding

3.A) Impact of the Affordable Care Act

3.A.1) Uninsured and Poverty - Please see **Figure** 8 below

Figure 8. FY 2015 San Francisco EMA Uninsured and Poverty Data Table
Reporting Period: March 1, 2013 - February 28, 2014

(Note: The chart below provides data only for clients in the Ryan White system of care as contained in the regional ARIES database)

Client Characteristics	Number	% of Ryan White Population
▪ Total persons with HIV who are enrolled in Medicaid, Medicare, and marketplace exchanges[1]	**5,477**	**77.6%**

Client Characteristics	Number	% of Ryan White Population
▪ Total persons with HIV without insurance coverage, including those without Medicaid or Medicare[2]	**2,061**	**29.2%**
▪ Total persons with HIV living at or below 138% of 2014 Federal Poverty Level (FPL)	**5,674**	**80.4%**
▪ Total persons with HIV living at or below 400% of 2014 FPL	**7,056**	**100.0%**
▪ Percentage of FPL used to determine Ryan White eligibility in the San Francisco EMA: **≤ 400%**		

Source: ARIES Statistical Analysis Report (STAR), 9/2/14.
[1]Does not include persons whose insurance status is listed as "unknown" at any time within the reporting period.
[2]Includes persons covered under Ryan White (without insurance coverage) at any time within the reporting period.

3.A.2) Impact of Insurance Expansion: The advent of health care reform through the Affordable Care Act (ACA) has resulted in significant, positive change in regard to the number and proportion of low-income persons with HIV in our region who benefit from affordable and more accessible health insurance coverage. California, which has eagerly embraced the ACA since its inception, began the process of implementing the ACA over three years ago through its "Bridge to Reform" Section 1115 Medicaid Demonstration Waiver program which created the State's **Low Income Health Insurance Program (LIHP).** Eligibility and benefits available through LIHP, which was launched on July 1, 2011, mirrored to the fullest extent possible the expanded income eligibility levels and care packages of the expanded Medicaid coverage that became available on January 1, 2014. LIHP enrollees were split into two income-based categories: Medicaid Coverage Expansion (MCE) enrollees with family incomes up to 133% (later 138%) of Federal Poverty Level (FPL) and Health Care Coverage Initiative (HCCI) enrollees with incomes above 133% (138%) and up to 200% of FPL. During the period in which the program was operating, **19** different LIHPs operated to service Medicaid Coverage Expansion enrollees in a total of **53** of California's 58 counties.

Particular attention was given to ensuring that the needs of persons with HIV would be effectively met through the California LIHP program. New laws and regulations were enacted to facilitate data sharing between the LIHP program and the California AIDS Drug Assistance Program (ADAP) operated by the California Office of AIDS. Frequent policy briefs were developed and circulated beginning in 2011 to provide guidance on overlapping benefits or benefits conflict involving LIHP and other public and private insurance programs. Most importantly, activists throughout the state worked to ensure that persons with HIV who qualified for expanded Medicaid coverage would

continue to receive the same high level of care they are able to receive through services funded wholly or in part by the Ryan White program. Among other outcomes, this resulted in specific policy directives regarding which HIV benefits would be coverable under expanded Medicaid and the new insurance exchange and which would remain eligible for reimbursements solely through Ryan White care.

The LIHP Program proved to be a tremendous and unprecedented success. When LIHP coverage ended at midnight on December 31, 2013, more than **630,000** Californians automatically became beneficiaries of expanded Medicaid service available through the Affordable Care Act.[35] An additional **24,000** individuals who did not qualify for expanded Medicaid began the process of obtaining coverage through the State's health insurance exchange, **Covered California** (see Marketplace Options section below). The outreach activities begun through the LIHP program have continued in 2014, resulting in stunning decreases in uninsured populations in our state. According to the Los Angeles Times, over the nine-month period between September 2013 and June 2014 alone, the percentage of Californians without health insurance was **reduced by half** as a result of ACA coverage, with the proportion of uninsured persons in the state dropping from **22%** in late September 2013 to **11%** by early June 2014.[36]

Unfortunately, because of HIV case reporting restrictions that still exist in California, many of which stemmed from the early years of the epidemic when the fear of HIV status disclosure was a very real possibility, it is impossible to currently ascertain the exact number of persons with HIV who have successfully transitioned to expanded Medicaid coverage through LIHP and the ACA. Local providers have reported percentages ranging anywhere from 5% to 12% of client populations transitioning to expanded Medical coverage as a result of the ACA, but these figures are wholly anecdotal. We do know that because of the extremely low incomes on which most persons with HIV served by Part A agencies already live, the percentage of clients eligible for benefits either through expanded Medicaid or Covered California does not represent a dramatic percentage of each agency's client base. The County of San Francisco has recently made a formal request to the State ADAP Program for data on how many individuals previously enrolled in ADAP transitioned to drug coverage through expanded Medicaid and other marketplace options, since that information is tracked at the ADAP level, and a response is expected soon.

3.A.3) Outreach and Enrollment: The San Francisco HIV community began preparing for health care reform by forming a local **Health Care Reform Task Force** in 2012 that was supported with a grant from Blue Shield of California. The Task Force was made up of leadership from San Francisco HIV Health Services and HIV Prevention services; the co-chairs of the San Francisco HIV Health Services Planning Council; and local providers and HIV policy professionals Facilitated by a local consulting firm, the group met frequently and reviewed rollout of the ACA by the State, LIHP, and local entities, and developed ways to improve communication, systems, processes to help educate and recruit clients and to keep patients with HIV from falling through the cracks. The Task Force successfully advocated with the State around a number of key HIV policy and procedural issues, including how to transition clients from ADAP to Medi-Cal and how to facilitate the transition to HRSA 6-month eligibility renewal requirements. The process culminated with **three** town hall meetings for clients in the fall of 2013 to educate the community regarding the impact of ACA in relation to HIV care and Ryan White services.

The State of California Department of Health Care Services worked in close contact with LIHP programs throughout the state - including those serving the three counties of the San Francisco EMA - to educate health care providers and agencies regarding LIHP program eligibility and benefits and to train benefits program recruiters and assistants. HIV service agencies in the San Francisco EMA were active participants in this process, and virtually every Part A-funded provider incorporated staff who had been fully trained in LIHP regulations and eligibility screening enrollment procedures. San Francisco HIV Health Services participated in collaborative efforts to provide early outreach and education regarding the LIHP program beginning in 2011, and worked with the San Francisco HIV Health Services Planning Council to develop guidelines and informational options for Part A-funded agencies on LIHP program options.

These efforts were magnified in 2013 when Covered California began training thousands of **Certified Enrollment Counselors** to provide in-person counseling and assistance to consumers in need of help applying for Covered California programs. Many HIV agency staff became certified as Enrollment Counselors, and were reimbursed on a per-enrollment basis for their assistance in linking new low-income individuals and families to Covered California services. Counselors were particularly valuable in providing assistance in a culturally and linguistic appropriate manner to distinct consumer sub-groups throughout California, many of whom had been disenfranchised from health care services on a multi-generational basis.

To support the effort to educate and advocate for clients during the transition to ACA, San Francisco HIV Health Services funded the locally based **Positive Resource Center** to create a program to provide individual client advocacy, education, and referral for clients who were having issues with ACA transitioning. For example, a large number of local clients have had problems with state Office of AIDS Health Insurance Premium Program (HIPP) program sending the wrong checks or sending checks addressed to the wrong client or provider, which in turn was leading clients to have been dropped or nearly dropped from Covered California plans. Advocates employed through the program intervened with the State to correct errors and ensure that clients did not lose their insurance. Advocates also helped PLWHA avoid selecting plans or clinics that would lead to them not being able to continue with their current HIV provider.

3.A.4) Marketplace Options: 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, and it has become an even more fundamental component with the advent of expanded ACA coverage. Based on a report from the California Medi-Cal Office, a total of **$99,909,988** in HIV-specific Medi-Cal expenditures were incurred across the EMA's three counties in calendar year 2012, the last date for which statistics have been provided. Just under **one-half** (**46.0%**) of HIV Medi-Cal expenditures in the EMA were for **HIV-related medications** (**$45,932,154**); another **8.7%** (**$8,706,066**) were for **inpatient care;** and **18.2%** (**$18,205,732**) were for **intensive and skilled nursing care.** The remaining **27.1%** was dispersed among other categories. A total of at least **5,339** unduplicated HIV-positive individuals were Medi-Cal recipients in 2012. Upcoming data on Medi-Cal HIV expenditures expected to be released later this year are expected to shed critical light on the extent to which Medi-Cal expansion has improved care access for low-income persons with HIV.

In addition to expanding Medicaid enrollment through LIHP, California was one of the very first states to develop a **state-based health insurance exchange** authorized by the ACA, which was conditionally approved to operate by the U.S. Department of Health and Human Services in 2011. The exchange, named **Covered California,** is essentially a **virtual marketplace** that allows citizens and legally recognized immigrants who do not have access to affordable employment-based coverage and are not eligible for Medicaid or other public coverage to purchase subsidized health insurance if they earn up to 400% of FPL. Covered California health plans are also available to small employers through the Small Business Health Options Program (SHOP). In early 2013, the California Simulation of Insurance Markets (CalSIM) model predicted that at least 840,000 individuals with family incomes below 400% FPL would purchase insurance offered through Covered California and receive income-based premium tax credits to subsidize the out-of-pocket cost of coverage in 2014.[37] The vast majority of these individual are eligible for premium tax credits expected to range from 36 to 54% of enrollees in 2014.[38] However, during the historic first open-enrollment period from November 15, 2013 through April 15, 2014, more than **1.3 million** Californians chose health insurance through Covered California for coverage in 2014, while millions of additional Californians learned that they qualified for free or low-cost health coverage through Medicaid. Covered California today provides a critical bridge to affordable care for many persons with HIV in the San Francisco EMA whose incomes do not qualify them for expanded Medicaid coverage.

San Francisco residents have also had a longer-standing option of enrolling in the **San Francisco Health Plan,** a licensed community health plan created by the City and County of San Francisco that provides affordable health care coverage to over **100,000** low and moderate-income families. Created in **1994**, the San Francisco Health Plan's mission is to provide high quality medical care to the largest number of low-income San Francisco residents possible, while supporting San Francisco's public and community-minded doctors, clinics, and hospitals. Health Plan members have access to a full spectrum of medical services including preventive care, specialty care, hospitalization, prescription drugs, and family planning services and members choose from over **2,600** primary care providers and specialists, **9** hospitals and over **200** pharmacies – all in neighborhoods close to where they live and work.

San Francisco also operates **Healthy San Francisco,** a program designed to make health care services available and affordable to uninsured San Francisco residents. Operated by the San Francisco Department of Public Health, Healthy San Francisco is available to all San Francisco residents regardless of immigration status, employment status, or pre-existing medical conditions and currently provides health coverage to over **50,000** uninsured San Francisco residents. To be eligible for Healthy San Francisco, enrollees must be a San Francisco resident and have income at or below 500% of Federal Poverty Level. Depending on income, enrollees pay modest fees for health coverage. The City and County are currently working with the State of California to finalize an effective integration between the two programs that ensures that persons with HIV wishing to transfer from Healthy San Francisco to Covered California are able to retain their current provider or that they have effective options for receiving high-quality, HIV specialist care from culturally appropriate providers.

3.A.5) Successes / Outcomes: Because of the relatively recent enactment of ACA and the lack of extensive data on impacts of Medicaid expansion on persons with HIV, it is still not possible to document specific or detailed successes related to the expansion process in regard to low-income persons with HIV. However, as noted above, California has been extremely successful in enrolling low-income individuals in both expanded Medicaid and Covered California exchange services, with the percentage of Californians without health insurance dropping by **100%** due to expanded ACA coverage, from **22%** in late September 2013 to **11%** by early June 2014.

3.B) Impact of Reduction in Ryan White Formula Funding

Impact of Decline in Formula Funding: The San Francisco EMA has experienced three sudden and dramatic reductions in Ryan White Part A formula funding over the past three fiscal years. with support dropping from $25,640,788 in FY 2011 to $15,140,465 in FY 2014, a loss of $10.5 million or 41% in only two short years. Between FY 2013 and FY 2014 alone, San Francisco's Ryan White formula allocation was reduced by **$2,027,474,** dropping from **$17,925,024 to $15,140,564.** These dramatic cuts are related to changes in the hold harmless provision of the Ryan White HIV/AIDS Treatment Extension Act of 2009 which did not include a supplemental funding restoration to the San Francisco EMA for the period 2010 - 2014. While our region was fortunate to have some of these cuts restored out of San Francisco County General Funds, and was awarded an increase of **$931,526** in FY 2014 Part A Supplemental 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. Moreover, neither Marin nor San Mateo County had any measure of reduced HIV care funding restored through local dollars. 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 supplemental funding through the FY 2015 allocation process to avoid reductions in service availability and quality in the EMA.

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 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.

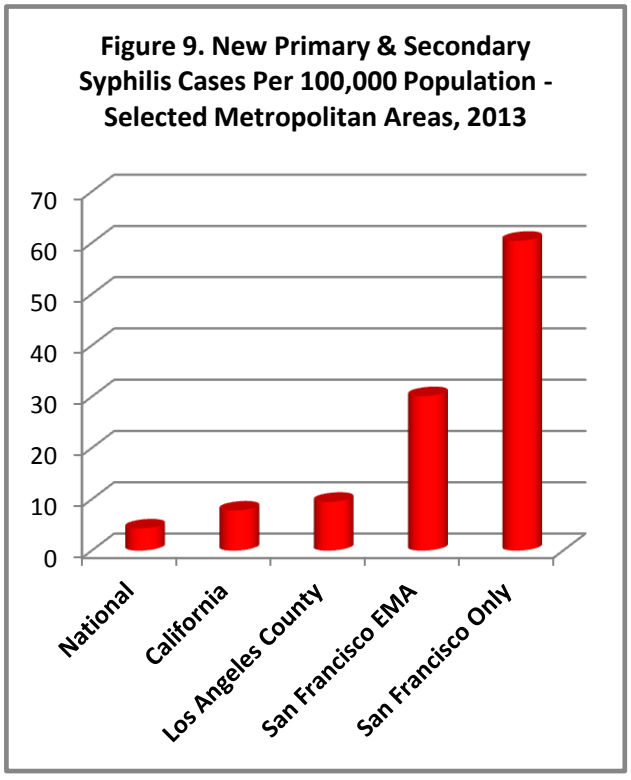
Planning Council and Community Response: The San Francisco HIV Health Services Planning Council continually monitors the status of Ryan White and other public funding and works in partnership with HIV Health Services to develop effective responses to formula funding reductions. This includes assessing client needs and obtaining consumer input through both formal and informal processes, including direct Planning Council involvement, a formal complaint process, and a range of consumer satisfaction surveys; soliciting input from HIV service agencies in the EMA regarding emerging service issues and barriers; and conducting funding analyses across the full spectrum of HIV funding resources and programs. There can be no doubt that advent of the Affordable Care Act has been well timed to correspond to recent dramatic reductions in HIV formula funding in our EMA. Expanded care has allowed the EMA to continue to meet the ambulatory medical care needs of persons living with HIV while enhancing services to effectively identify, link, and retain complex and multiply diagnosed low-income PLWHA in care.

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

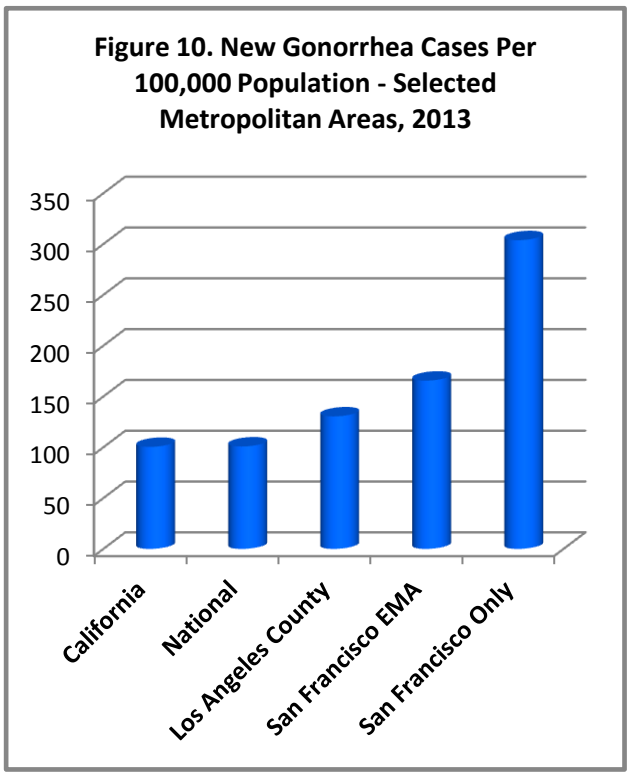
3.C.1) Quantitative Evidence on Co-Morbidities - See **Table** in **Attachment 5**

3.C.2) Narrative on Cost and Complexity of Providing Care

Sexually Transmitted Infection (STI) Rates: The growing crisis of **sexually transmitted infections** is of significant concern for the future of the HIV epidemic in our region**.** In terms of **syphilis,** for example, the San Francisco EMA continues to confront a **major epidemic** that has been escalating for the past half decade, rising **more than 500%** since 2000. In 2013, a total of **558** new primary and secondary syphilis cases were diagnosed in the EMA, representing a **144% increase** over the **229** cases reported just six years earlier in 2007.[39] The combined EMA-wide syphilis rate of **31.4** per 100,000 in 2013 is **more than three times** the statewide rate of **9.3.** Within the City of San Francisco alone, a total of **482** new syphilis cases were reported in 2013 for a shocking incidence rate of **58.0** cases per 100,000, a rate **nearly eight times higher** than the statewide rate and **more than ten times higher** than the national syphilis rate of

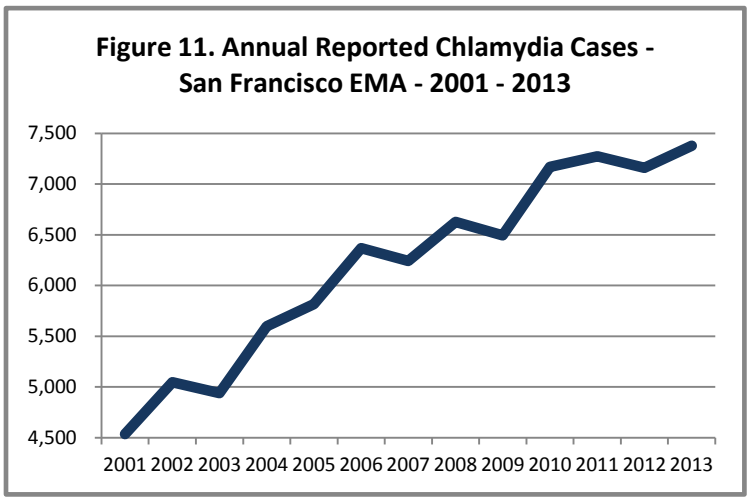


4.3 cases per 100,000 in 2011 (see **Figure 9**). **San Francisco County has by far the largest syphilis infection rate of any county in California,** more than **four times** the rate of the second highest county, Kings County (**13.7** per 100,000) and more than **five times** that of Los Angeles County (**11.1** per 100,000).[40]



The EMA is also experiencing a significant **gonorrhea** epidemic. A total of **2,941** new gonorrhea cases were identified in the San Francisco EMA in 2013, for an EMA-wide incidence of **165.6** cases per 100,000, a rate that is nearly **65% higher** the 2013 California rate of **100.4** cases per 100,000.[41] [42] The city of San Francisco's 2013 gonorrhea incidence of **303.8** per 100,000 (n=**2,525**) is **nearly three times** the national rate of **100.8** cases per 100,000 and **more than three times higher** than 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 of **181.1** per 100,000 (see **Figure 10**).[43]

The San Francisco EMA's **Chlamydia** epidemic also continues to rise precipitously. A total of **7,377** new cases of Chlamydia were diagnosed in the San Francisco EMA in 2013. This represents a **23.1% increase** over the **5,816** cases diagnosed in 2005 and a **57.9% increase** since 2001 (see **Figure 11**).[44] The 2012 EMA-wide Chlamydia incidence stood at **402.5** per 100,000, while the rate for the City of San Francisco was **605.3** cases per 100,000. By comparison, the 2012 incidence for California was **448.9** cases per 100,000 while the national rate was **426.0**.[45]



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.**[46] 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.[47] 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.**[48] Such studies suggest that the total cost of treating new STIs in the SF EMA may be as high as **$9.7 million** per year, including an estimated **$2.3 million** to treat STIs among persons with HIV, with another **$7.5 million** in annual costs potentially resulting from the need to treat persons infected with HIV as a result of transmission facilitated through other STIs.[49]

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.[50]

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 2014* report, Marin, San Francisco, and San Mateo Counties – the three counties that make up the San Francisco EMA – **are tied with one another as the three least affordable counties in the nation** in terms of the minimum hourly wage needed to rent an average two-bedroom apartment, which currently stands at **$37.62 per hour** (see **Figure 12**).[51] 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".[52]

Figure 12.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs, 2014

County	Hourly Wage Needed to Rent a Two-Bedroom Apartment at HUD Fair Market Rents
San Francisco County, CA	$ 37.62
Marin County, CA	$ 37.62
San Mateo County, CA	$ 37.62
Honolulu County, HI	$ 35.00
Nantucket County, MA	$ 34.60
Honolulu County, HI	$ 33.98
Santa Clara County, CA	$ 31.71
Orange County, CA	$ 31.62
Nassau County, NY	$ 31.02
Suffolk County, NY	$ 31,02
Kauai County, HI	$ 30.71

On January 24, 2013, the City of San Francisco conducted its bi-annual 24-hour homeless count which identified a total of **6,436** homeless men and women living on the streets or in jails, shelters, rehabilitation centers, or other emergency facilities, a slight decrease from the 2011 total of **6,455**.[53] At the same time, the 2013 San Mateo County Homeless Census and Survey identified a total of **2,281**

homeless people on the night of January 24, 2013, including **1,229** unsheltered homeless people living on streets and **982** sheltered homeless people[54] while recent estimates place the number of homeless people in Marin County from as low as **1,770** to as high as **6,000**.[55] 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**.[56] 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.[57] 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.

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. At least **1,283** 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. 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.[58] 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.[59] 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.[60]

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

The San Francisco EMA is also home to **San Quentin State Prison**, California's oldest and largest prison. Opened in 1852, the prison houses an average daily population of **5,222** inmates in facilities originally designed to house 3,317 individuals. The prison also serves

as the identification point for a large number of persons with HIV, many of whom are paroled to the Bay Area and seek HIV services following release. Over a three year period from January 1, 2010 through December 31, 2012 a total of **7** new AIDS cases were diagnosed at San Quentin Prison, while a total population of **346** persons living with HIV and AIDS were being housed at the prison as of December 31, 2012. More than **half** of these inmates (**62.1%**) were infected through injection drug use, including MSM injection drug users, as compared to **20.7%** of all persons living with HIV/AIDS in the EMA. **African Americans** are highly overrepresented among the San Quentin HIV population, representing **49.4%** of all PLWHA at the facility as of 12/31/12.

An analysis of epidemiological and client data reveals a range of factors that are strongly associated with significantly increased cost and complexity of care for formerly incarcerated populations with HIV in the Bay Area. For example, of the **623** HIV-positive individuals served by Forensic AIDS Project and released from SF jails in the three years through June 30, 2012, **12.7%** were **women** – **double** the percentage of women living with HIV/AIDS in the EMA (**6.5%**) – and **4.7%** were **transgender persons – more than double** their representation among the EMA's total PLWHA population (**2.2%**). Reflecting high rates of injection drug use among incarcerated populations, **27.9%** of persons with HIV in the SF jail system had been infected through injection drug use alone, as compared to **6.9%** of the overall PLWHA population, while MSM / IDU cases accounted for **18.6%** of jail populations, versus **13.8%** of all PLWHA. These findings are mirrored in a study of young injectors under age 30 in San Francisco, which found that **86%** had a lifetime history of incarceration; **56%** had been incarcerated in the past year; and **42%** were infected with hepatitis C – a critical marker of potential HIV infection.[61] 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.

The 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.[62]

The high prevalence of **mental illness** and **mental health issues** in the San Francisco EMA further complicates the task of delivering effective services and retaining persons with HIV in care. The San Francisco Department of Public Health, Behavioral Health Section reported in its most recent report that **12,000** seriously emotionally disturbed children and youth and **32,000** seriously mentally ill adults live in San Francisco, and that up to **37%** of San Francisco's homeless population suffers from some form of mental illness.[63] 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.[64] 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%.**[65] 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.[66]

The problem of **substance use also** 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.[67] 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.[68] 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**.[69] 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,[70] and recreational crystal use has been linked to **30%** of San Francisco's new HIV infections in recent years.[71]

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.[72] 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.**[73] 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.[74]

3.D) Coordination of Services and Funding Streams

3.D.1) Report on Availability of Other Public Funding - See **Table** in **Attachment 8**

3.D.2) How Part A Funds Address Gaps in Service: 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 and that they address identified service gaps at all levels of client care and support. The Planning Council reviews annual service category summaries that include a detailed listing of all Ryan White and non-Ryan White funding sources for each category, including sources such as ADAP, Medicaid and Medicare support, public entitlement programs, private insurance and HMO support, Veterans Administration programs, City and County funds, HOPWA and SAMHSA grants, and State mental health funds. The Grantee also ensures that services are coordinated to maximize accessibility of services, while seeking every possible alternate source of funding apart from Part A to support HIV care.

The San Francisco EMA is also 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.

In 2008, the San Francisco EMA commissioned and completed a **Comprehensive HIV Health Services Needs Assessment** (the last comprehensive needs assessment conducted by the Planning Council in our region), which included in-depth client surveys completed by **248** PLWHA in all three counties and a series of **4** population-specific focus groups involving monolingual Spanish-speaking persons; persons age 55 and older; Marin County residents; and formerly incarcerated individuals. [75] 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.

METHODOLOGY

1) Planning and Resource Allocation

1.A) Letter of Assurance from Planning Council Chairs - See **Attachment 7**

1.B) Description of the Community Input Process

1.B.1) Structure of the Community Input Process: As in previous years, the San Francisco EMA employed a **multi-phased process** for FY 2015 priority-setting and allocations. This process began early in the year with planning meetings of the Council's Steering Committee to assess preliminary data and develop a set of initial prioritization recommendations. Planning Council members also conducted a review of progress toward the Objectives and Action Steps contained in its most recent 2012-2014 Comprehensive HIV Services Plan. A broad range of background materials and information were presented to the Council to provide a background to current service access and funding trends in the EMA. This year's **Prioritization and Allocation Summit** took place in San Francisco on September 5, 2014. The Summit included an analysis and discussion of trends and factors in the EMA, including review of epidemiological information, client data, and HIV funding in the EMA, including Ryan White and Medicaid funding. This was followed by a discussion and vote on FY 2015 resource allocations for the EMA and development of emergency funding scenarios to help cope both with potential decreases in Part A funding and, more significantly, with ongoing State HIV budget cuts.

Since its inception, the San Francisco HIV Health Services Planning Council has utilized a wide range of quantitative and qualitative data to help Planning Council members assess needs, measure progress, identify gaps, prioritize services, and allocate resources. The Planning Council has also consistently incorporated broad-based consumer participation to arrive at a balanced and effective set of goals and objectives to improve the region's comprehensive system of care. These activities took on greater urgency in the process of determining FY 2015 priorities and allocations as the EMA has struggled to cope with several years of dramatic cuts in Part A funding while working to determine the impact of ACA implementation on low-income persons with HIV. The need to balance reduced funding with the Part A requirement to provide an effective, comprehensive system of care for a continually expanding HIV-positive population compelled the Council to once again make some extremely difficult decisions – decisions that will inevitably impact the quality and scope of HIV services in the region.

1.B.2) Description of the Community Input Process

Consideration of Needs of Persons Not in Care, Persons Unaware of their HIV Infection, and Historically Underserved Populations: The San Francisco HIV Health Services Planning Council utilized a broad range of approaches to incorporate the needs of out of care PLWHA throughout FY 2015 its prioritization and allocation process. The Council utilized the Unmet Needs Framework as a tool to quantify the number of individuals living in the EMA who are aware of their HIV status but are not currently in care. The Council also utilized a demographic chart of unmet needs populations developed the San Francisco HIV Epidemiology Unit which broke down the out of care population by projected demographic categories and helped the Council project some of the potential needs of out of care individuals who may be brought back to the system in the coming months and years. The Council continued to be informed by the findings of its previous Comprehensive Needs Assessment which included significant qualitative input from out of care populations and has influenced decisions on how best to tailor services to overcome barriers to care for PLWH. The Council also received briefings on San Francisco

neighborhood-based community viral load, providing information on intermittent care seekers.

The Planning Council relied on a combination of quantitative and qualitative data to assess the needs of HIV-unaware populations into its current prioritization and allocation cycle. From a quantitative standpoint, the most important document the Council considers is the EMA-Wide Epidemiological Chart and Epidemiology Report developed each year for the Ryan White Part A application which utilizes epidemiological consensus to provide a reliable estimate of the size and scope of the population of persons living with HIV in the region, including persons with HIV who are unaware of their status. The EMA has developed this chart each year for nearly a decade, and it is used by the Planning Council both to anticipate new populations who may enter the system in the future and to flag potential emerging challenges in the epidemic related to emerging epidemiological trends. From a qualitative standpoint, the Council works in close partnership with the San Francisco HIV Prevention Section to plan collaborative approaches to HIV outreach, testing, and care linkage and to develop points of integration between prevention and care wherever possible. A large share of these activities have been taken up through the local ECHPP process, which incorporates strong participation by members of both Councils and continually reports back to the Councils on new initiatives related to HIV-unaware groups.

The San Francisco Planning Council has placed a historical emphasis on meeting the needs of **underserved populations**, and on developing care systems which facilitate entry and retention in care for these groups. This approach is consistent with the overall purpose of Ryan White funding, which is in part to develop systems that allow highly underserved individuals to access high-quality HIV care, treatment, and support services regardless of income status. The San Francisco EMA's entire model of care is structured around the need to ensure access to care for underserved populations, including its Centers of Excellence program, which is specifically designed to address retention and care access barriers for underserved groups with special needs such as women, African Americans, Native Americans, and recently incarcerated individuals. Centers of Excellence service data consistently attests to the success of this approach in achieving high care representation among groups who most commonly face barriers to health care access in America, including low-income individuals and families, persons of color, women, gay and bisexual men, transgender persons, active substance users, homeless individuals, and persons with mental illness. The Council continues to use its success in meeting the needs of these populations as a benchmark for tracking its own effectiveness in addressing the goals of the Ryan White program.

Involvement of Persons Living with HIV/AIDS: As in previous years, persons living with HIV and AIDS (PLWHAs) were integrally involved in all phases of the FY 2015 priority-setting and allocation process. Self-identified persons living with HIV currently make up **55%** of the membership of the San Francisco HIV Health Services Planning Council, including **16** non-aligned consumers comprising **43%** of Council membership. Council bylaws require that at least one Council Co-Chair be a person with HIV and a consumer of Ryan White services, and the Council strives to ensure that at least one co-chair for each committee is a person with HIV.

The Council also relied heavily on its **2008 San Francisco EMA Health Services Needs Assessment**, which included in-depth client surveys completed by 248 persons living with HIV and/or AIDS in all three counties; a series of 3 population-specific focus

groups attended by a total of 26 individuals; and on-on-one interviews with a total of 11 recently incarcerated individuals.[76] The assessment over-sampled members of the **African American** community to better identify needs among members of this hard-hit and historically underserved population, with **38.9%** of the total study sample consisting of African Americans living with HIV/AIDS. To expand our understanding of **homeless populations**, fully **21%** of all those participating in the needs assessment were also persons considered to be homeless.

The Council also utilized a **Follow-Up Qualitative Study to the Needs Assessment** published in June 2010 which provided an in-depth exploration of the needs of **three** key emerging subpopulations in the San Francisco EMA: African American women, older adults, and hepatitis C co-infected individuals.[77] The study also included a focus group made of HIV service providers. Among the most significant findings of the study was the fact that while persons 50 and older with HIV are generally satisfied with the quality of medical care they are receiving, they are concerned that medical providers are not prepared to deal with the health needs of the burgeoning HIV-positive geriatric population. Participants are also concerned that doctors may not be able to differentiate which symptoms are specific to aging versus HIV, and there was general concern regarding the lack of research on the implications of taking HIV medications over long periods of time. The Needs Assessment was instrumental in guiding FY 2015 prioritization and allocation, and ensured that the needs and perspectives of persons living with HIV/AIDS – including those not in care – were continually incorporated into the process.

Consideration of Current Data Sources: As in past years, the Planning Council received a range of high-quality data - including unmet needs data - to assist in prioritizing FY 2015 services and allocating resources, with an emphasis on HRSA-identified core medical services. Among the data presented, reviewed, discussed, and incorporated by the Council in its decision-making this year were the following:

- Background information on requirements and parameters of the Ryan White HIV/AIDS Treatment Extension Act of 2009, including definitions of core service categories;
- A detailed analysis of each priority service category funded and not funded by the Council in FY 2014 by county, including service definitions; budgeted and actually funded service category amounts; populations served; key points of entry; utilization reviews; other funding sources available in each category; and possible impacts of cuts in each service category;
- A comprehensive, updated HIV/AIDS Epidemiology Report by the SF AIDS Office detailing current PLWHA populations and discussing current trends in the epidemic;
- A detailed analysis of client-level data reported through the ARIES data system for the period March 1, 2013 through February 28, 2014, including information on the demographic characteristics and changing health status of Ryan White-supported clients and service utilization data related to all Part A services;
- A summary of findings from needs assessments commissioned by the Planning Council, including the Comprehensive Assessment and Follow-Up Qualitative Study;
- A summary estimate of unmet need among PLWHA in the San Francisco EMA utilizing HRSA's unmet needs framework;
- A detailed presentation on other funding streams in the EMA, with a special focus on federally funded programs and on programs funded through MAI support, as well as

Part B, Part C, Part D, and Part F funding through the San Francisco Department of Health, and other sources;

- A review of goals and objectives from the 2012-2014 Comprehensive HIV Health Services Plan, along with updated progress reports for each goal, objective, and action step; and
- Consensus input to the Planning Council from the San Francisco HIV/AIDS Provider Network, a group of 43 community-based, non-profit HIV service agencies in the San Francisco EMA meeting the needs of persons living with HIV and AIDS.

Utilization of HIV/AIDS Epidemiology Data: The Council fully incorporated changes and trends in HIV/AIDS epidemiology data in this year's priority-setting and allocation process. The Council reviewed a comprehensive, updated HIV/AIDS Epidemiology Report prepared by the San Francisco AIDS Office detailing current PLWA / PLWHA populations and discussing current trends in the epidemic which directly influenced key prioritization and allocation decisions by the Council. For example, the Council affirmed its commitment to the Centers of Excellence program as a strategy for helping address growing HIV infection rates among young women of color and MSM of color. The Council also discussed the growing proportion of PLWHA over 50 years of age in the EMA, identifying the need for more information to meet the needs of these groups, and to integrate this care into emerging approaches for HIV-related geriatric services. This included receiving an update on an ongoing grant to HIV Health Services through the California HIV/AIDS Research Program that is supporting the development and evaluation of innovative new models of care for persons with HIV 50 and older at two of the largest HIV clinics in San Francisco: Ward 86 at San Francisco General Hospital and the 360 Program at the University of California San Francisco Medical Center.

Applying Cost Needs Data to Part A Service Allocation: The Planning Council consistently incorporates cost data into its considerations, including information on potential new coverage reimbursement made possible through the Affordable Care Act. The Council draws from a detailed reports prepared by HIV Health Services for each funded and unfunded Part A service category which includes a full utilization review for each Part A service category listing total dollar amounts, unduplicated clients and cost per unit of service; a listing of all non-Part A funding sources available for each category; a description of issues and trends affecting the categories; and a description of possible impacts of further cuts. These data are accompanied by cost estimates related to care for special populations. The Council also receives a detailed presentation on other funding streams in the EMA, including a summary of Part A, MAI, Part B, Part C, Part D, SF DPH, HOPWA, and other funding sources such as LIHP, Covered California, Medicare, private insurance funding, and funds provided through the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). The funding streams presentation also included information on the history, current funding and programmatic levels, challenges and gaps related to each funding source. All cost-related data directly influenced both prioritization and funding decisions made by the Council, including an increased commitment to the Centers of Excellence program as a strategy for creating greater cost-effectiveness in serving severe need populations, and a continuing emphasis on treatment adherence support as a strategy for avoiding later burdens on the system related to emergency hospitalization and home care.

Planning for Potential Fluctuations in the Part A Award: As in previous years, the Planning Council developed a **contingency plan** offering a blueprint for how the Council would respond to potential increases or decreases in FY 2015 Part A funding: 1) If allocation levels **remain the same**, allocations for all service categories will remain at flat funding; 2) If allocation levels are **decreased**, the first 10**%** of cuts will be made to service categories that are covered under California's ACA Essential benefits package, with remaining reductions over 10% applied proportionally to all Service Categories; and 3) If allocation levels are **increased**, allocations will be shared proportionately across all service categories.

Consideration of MAI Funding: As noted in the MAI section above, the Planning Council received a comprehensive summary of the specific services currently funded through Minority AIDS Initiative funding, and incorporated MAI allocations decisions into its overall FY 2021 allocations process. The summary detailed specific goals of the local MAI process; historical funding levels received in the region; previous and current expenditures with that funding; specific outcomes achieved in regard to minority health, health access, and service utilization; and a quantified report on the demographics of populations served through MAI funding. This report validated the success of the EMA's approach to MAI allocations, and affirmed the key role that MAI funding plays in helping reduce HIV disparities while meeting the needs of historically underserved populations.

Incorporation of Data on Other Federally Funded HIV/AIDS Programs: As noted above, the FY 2015 prioritization and allocation process incorporated ongoing consideration of both financial and programmatic data related to all federal sources of HIV/AIDS funding in the San Francisco EMA. In addition to Ryan White funding, this includes funding sources such as Medicaid and Medicare, the Centers for Disease Control and Prevention (CDC), and funds provided through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Potential Changes through the Affordable Care Act (ACA): In part through the work of the San Francisco Health Care Reform Task Force, the Planning Council has kept itself aware of current and impending changes through the Affordable Care Act (ACA) and has taken these potential changes into account while prioritizing and allocating FY 2015 resources. While the precise scope of changes to be realized through the ACA are still not yet full known, California and the San Francisco EMA have already felt the impact of shifting resources through implementation of ACA-eligible low-income persons in the California Low Income Health Program (LIHP), California's bridge to ACA care. Perhaps the most immediate impact in regard to FY 2015 Part A funding was a Planning Council vote to reduce funding this year for direct outpatient ambulatory health services and to increase funding for medical case management services to better support linkage to and retention in care for the region's hardest hit groups. As part of this process, the Planning Council applied for and received a HRSA Waiver to the 75 / 25 core services requirement for the 2014-2015 Ryan White Fiscal Year (see **Attachment 14**).

Integration of Prevention and Care Planning at the Part A Level: As part of our region's ongoing efforts to generate a truly comprehensive continuum of care model in which all elements of HIV outreach and care are linked from the point of outreach to viral suppression, the San Francisco HIV Health Services Planning Council and the San Francisco HIV Prevention Planning Council have both recently approved moving forward to developed a **merged HIV prevention and care planning council** beginning in

approximately March of 2016. Merging of these two longstanding and highly qualified bodies is a complex process, and the two groups have created a **Transition Planning Team** that will outline key details of the merged body, such as the composition and responsibilities of the merged executive committee, how often the new council will meet, etc. The Transition Planning Team will be comprised of the three co-chairs from each council as well as three additional members from each council as well as two staff each from HIV Health Services and HIV Prevention Services, pending formal approval in November by each council. The merged prevention and care planning council will take San Francisco's unparalleled knowledge and approaches to identifying new cases of HIV infection and providing high-quality, long-term treatment to suppress viral load to the next level, creating a unified system that has the potential to significantly reduce or even stem the crisis of HIV infection in our region.

1.C) Funding for Core Medical Services - See **Table** in **Attachment 8**.

WORK PLAN

A) HIV Care Continuum for FY 2015

A.1) Care Continuum Graph - See **Table** in **Attachment 9**

A.2) Care Continuum Narrative

How the Care Continuum is Utilized in Planning and Prioritization: The San Francisco EMA's HIV prevention and care continuum strategy reflects a forward-thinking understanding of how to best meet the needs of people living with and at risk for HIV (PLWARH). The framework outlined in **Figure 13** on the following page is an attempt to move beyond the concept of treatment as prevention in order to address HIV as a **holistic health issue**. The model exemplifies the belief that prevention, care, and treatment are **inextricably intertwined**, and prioritizes the needs of people **regardless of HIV status**. In fact, the needs of PLWH and those at risk are no longer as different as they had previously been seen to be, a reality that presents inspiring opportunities for affected communities to come together around a common vision and set of priorities, including ensuring access to health care and other services; providing a continuum of HIV prevention, care and treatment services using a holistic approach; and ultimately, as a result, "getting to zero".

As of 2014, the EMA continues to implement and enhance the efforts outlined in the 2012 Care and Prevention Plans, incorporating new HIV prevention science along the way. The upcoming merger of the EMA's Prevention and Care Planning Councils promises even greater integration across the full spectrum of engagement and retention in care, including new initiatives to better link outreach, testing, linkage, engagement, retention, and re-engagement services. In addition, the positive implications of the Affordable Care Act (ACA) on HIV prevention are just beginning to be revealed, and we are continually adapting the Strategy as needed, including through leveraging third party payment for HIV and other disease screening.