# FY 2016 PROJECT ABSTRACT

**Project Title:** Enhancing Outcomes the Continuum of Care: San Francisco EMA FY 2016 Ryan White Part A Competing Continuation Application
**Applicant Name:** San Francisco HIV Health Services
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**Total Funds Requested in Application:** $17,495,002

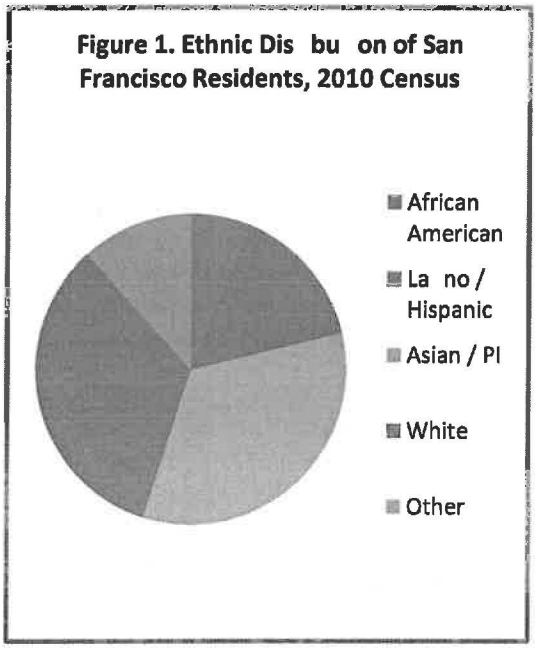
**General TGA Demographics:** The 2010 US Census population of the San Francisco EMA is **1,776,095,** including a population of **252,409** in Marin County, **805,235** in San Francisco County, and **718,451** in San Mateo County, with widely varying population densities among the three regions. **Over half** of the EMA's residents are people of color, including large Asian/Pacific Islander (**26.7%**), Latino (**19.3%**), and African American (**4.3%**) populations. Over **42%** of EMA residents speak a language other than English at home.
**HIV/AIDS Overview:** As of December 31, 2014, a total of **15,955** persons were living with HIV/AIDS in the San Francisco EMA, including **6,526** persons with HIV and **9,425** persons with diagnosed AIDS. This represents an EMA-wide HIV infection incidence of **898.3** cases per 100,000 persons. A total of **1,408** new HIV cases were diagnosed in the EMA over the three-year period between January 1, 2012 and December 31, 2014 alone
**Geography in Relation to Care:** The San Francisco EMA is a diverse region encompassing Marin County in the north, San Francisco County in the center, and San Mateo County in the south. San Francisco County covers an area of only **47** square miles, making it geographically the smallest county in California and the sixth smallest in the US. The density of San Francisco is **17,170** persons per square mile - one of the highest population densities of any city in the U.S. In both Marin and San Mateo Counties, cases and services are focused around the major cities bordering the north-south-running Highway 101.
**Continuum of Care:** Throughout the EMA, the emphasis on **high-quality, client-centered primary medical care services** is at the heart of the continuum of care, with medical case management providing individualized coordination and entry points to a range of medical and social services. In addition to major hospitals in the EMA, there are **seven** public clinics and **six** community clinics in San Francisco County, **two** public clinics in San Mateo County, and **one** public clinic in Marin County providing HIV/AIDS primary care. San Francisco's **seven Centers of Excellence** form an innovative network of HIV providers designed to involve and retain complex, hard-to-reach, and multiply diagnosed populations in care.
**Ryan White History:** San Francisco was one of the 16 original Title I EMAs funded by the Ryan White CARE Act in **1991** and first began receiving MAI funding in **1999.**
**Changes Resulting From ACA Implementation:** The most dramatic change in relation to ACA implementation has been a **31.8%** reduction in Part A expenditures for Outpatient Ambulatory Health Services from FY 2014 to FY 2015, from **$4,252,006** expended for primary medical care in FY 2014 to a projected **2,901,207** to be expended in FY 2015.
**Continuum-Related Successes and Challenges:** The San Francisco EMA has achieved an unprecedented level of success in reducing the number of persons with HIV in the EMA who are unaware of their serostatus, currently estimated at **6.4%.** At the same time, the EMA's viral load suppression rates of **68%** far surpass the national average of **25%.**

**ENHANCING OUTCOMES ALONG THE HIV CONTINUUM OF CARE:**
**SAN FRANCISCO EMA FY 2016 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) requests **$17,495,002** in Ryan White Part A Formula and Supplemental funding for 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 ensure a seamless, comprehensive, and culturally competent system of care focused on the complementary goals of reducing inequities and disparities in HIV care access and outcomes and ensuring parity and equal access to primary medical care and support services for all residents in the region. The FY 2016 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 highlights expanded integration with HIV outreach, testing, linkage, and care retention services and incorporates the perspectives and input of a broad range of consumers, providers, and planners from across the region, as well as findings of key data sources described below. The FY 2016 Part A application presents an 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, creates 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 mirrors 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 and is joined by a diverse group 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 natives 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 Pro ile

### 1.A) HIV/AIDS Incidence and Prevalence Table - 2012 - 2014 - See **Figure 2** below

**Figure 2. HIV Incidence & Prevalence in San Francisco EMA 2012 - 2014**

| Reporting Categories | CY 2012 | CY 2013 | CY 2014 |
|---|---|---|---|
| **HIV Incidence:** Number of new HIV cases diagnosed during calendar year, including persons with AIDS | 541 | 450 | 417 |
| **HIV Prevalence:** Number of persons living with HIV at the end of calendar year, including persons with AIDS | 16,511 | 16,686 | 15,955* |

* The decrease in 2014 HIV prevalence is largely due to current address updates conducted in 2014 for San Francisco cases that had been lost to follow-up prior to 2012.

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

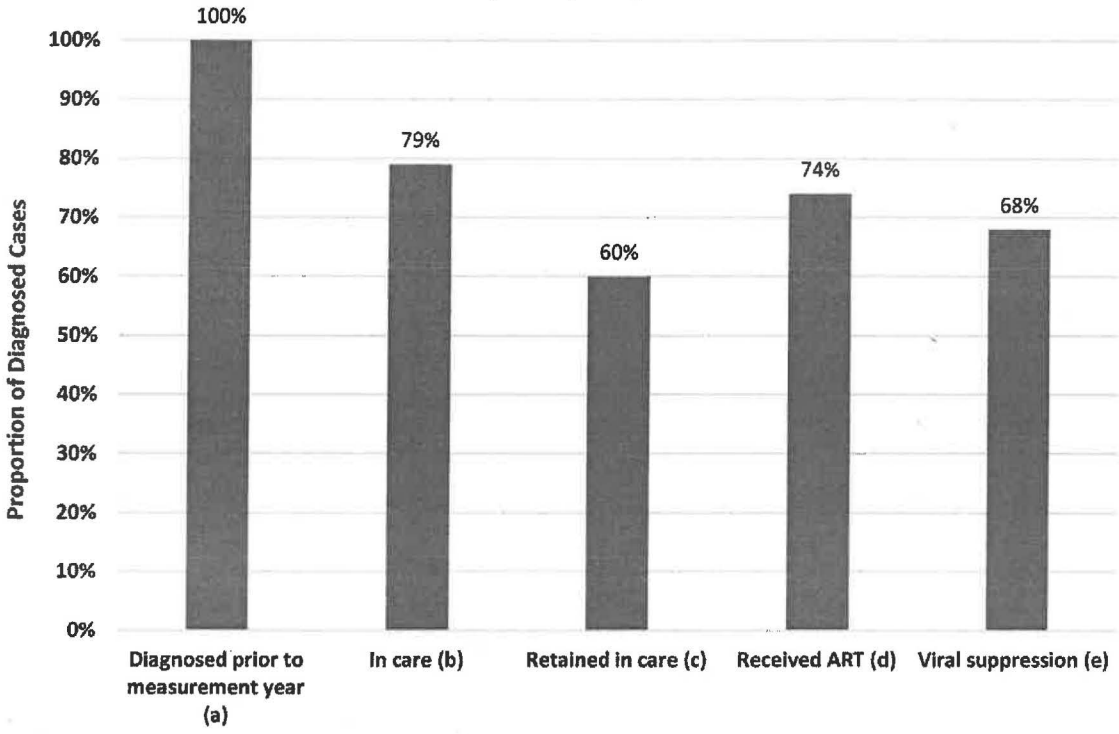
**2) HIV Care Continuum for FY 2016**

**2.A) Care Continuum Graph** - See **Figure 2** on following page

**2.B) Care Continuum Narrative**

**2.B.1) How the Care Continuum is Utilized in Planning and Prioritization:** The San Francisco HIV Care Continuum graph for 2014 was prepared using an analytic dataset provided by the California State Office of AIDS. PLWH were considered to be in the San Francisco EMA if they had been diagnosed with HIV prior to 2014 and were alive and residing within the EMA as of the end of 2014. Linkage to care within 3 months of diagnosis was **not** included in the analytic dataset provided - instead, an "in care" metric which indicated whether a person had at least one CD4 count or viral load test during 2014 was used (see graph for definitions of each stage of care).

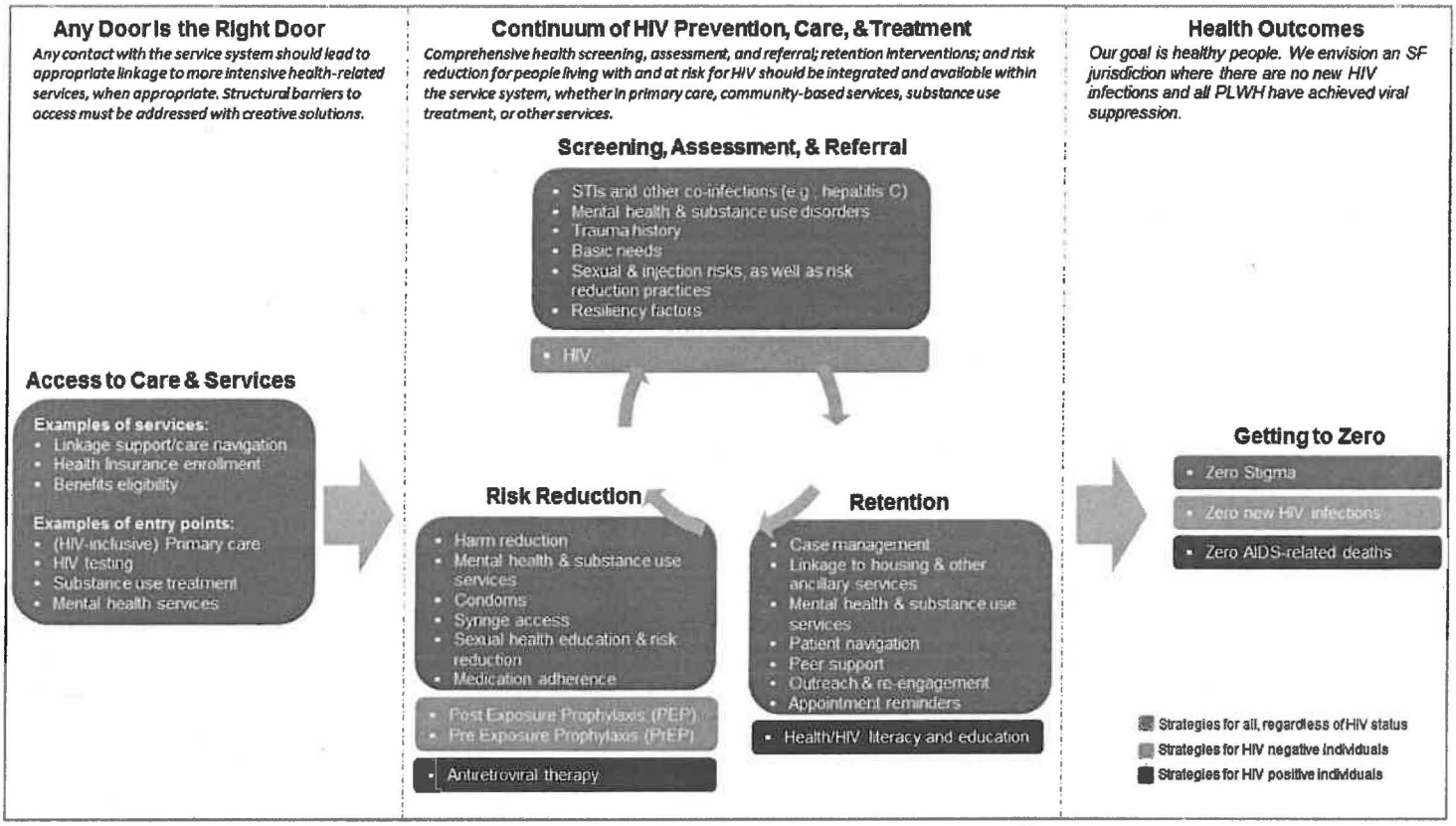
During calendar year 2014, **79%** of PLWH were in care, **60%** were retained in care, **74%** received ART, and **68%** achieved viral suppression. Persons aged 25-29 years were least likely of all age groups to be in care (**74%**), retained in care (**47%**) or virally suppressed (**56%**). Latino PLWH were the racial/ethnic group least likely to be in care (**74%**) or retained in care (**56%**). However, African American PLWH were least likely to achieve viral suppression (**60%**). Among HIV transmission risk groups, MSM and MSM-IDU had the highest proportion in care (**80-81%**) or retained in care (**60-61%**). MSM were more likely than MSM-IDU to achieve viral suppression (**72% versus 63%**). Transgender PLWH were more likely than males or females to be in care (**82%**) or retained in care (**67%**) but males were most likely to achieve viral suppression (**69%**).




(a) Includes persons who were alive and residing in EMA at end of 2014.
(b) >=1 CD4 or VL test during 2014.
(c) >=2 CD4 or VL tests at least 3 months apart during 2014.
(d) Based on chart reviews of a representa ve subset of SF pa ents in care.
(e) Last VL during 2014 <=200 copies/mL.

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 4** below builds from the concept of treatment as prevention **to** addressing HIV as a **holistic health issue**. The model illustrates how prevention, care, and treatment are **inextricably intertwined**, and prioritizes the needs of people **regardless of HIV status**. Given that with advances in treatment and prognosis the needs of PLWH and those at risk are no longer as different as they once were, there are increased 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" - meaning zero new infections, zero AIDS-related deaths, and zero stigma – may be within our reach for the irst time in the history of the epidemic..**

**Figure 4: San Francisco Jurisdiction Holistic Health Framework for HIV Prevention and Care**



As of 2015, 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 is resulting in greater integration across the full spectrum of engagement and retention in care, including new initiatives to better integrate outreach, testing, linkage, engagement, retention, and re-engagement services. In addition, as the impact of the Affordable Care Act (ACA) on HIV prevention begins to impact the service delivery system the EMA, has responded by adapting the Strategy as needed, including through leveraging third party payment for HIV and other disease screening.

**2.B.2) Systematic Approaches to Address Gaps in the Continuum of Care:** Advances in the knowledge regarding effective HIV prevention, care, and retention, along with the aggressive adoption of new HIV prevention technologies, have made a broad vision for healthy people and communities possible. The EMA is already seeing the results of its efforts on the prevention side of the continuum, with new the rate of new HIV infections steadily decreasing and with higher and higher percentages of PLWH achieving viral suppression. **Amazingly, "Getting to Zero" – zero new infections, zero AIDS-related deaths, and zero stigma – may be within our reach for the irst time in the history of the epidemic.** The San Francisco EMA is faring better on indicators compared with the state of California and the U.S., and has already achieved some of the National HIV/AIDS Strategy (NHAS) targets. While the SF jurisdiction is making marked progress in reduction in new HIV infections and improved health outcomes for PLWH, efforts in the coming years to further reduce disparities is vital.

Some of the factors that have likely contributed to these successes include the following:

- The EMA's realignment of HIV prevention funding in 2011/2012 to implement high-impact prevention;
- Increase HIV testing in San Francisco;
- Increased emphasis on early linkage to care and partner services, such as through the Linkage Integration Navigation Comprehensive Services (LINCS) program;
- Increased availability of pooled RNA testing to detect acute HIV infection beginning in 2011. Eighty-two acute diagnoses were made between November 2011 and October 2013 (Dr. Stephanie Cohen, personal communication, August 2014);
- SF's early adoption of a "universal offer of treatment" policy in 2010, which encouraged all primary care providers to offer HAART to all PLWHA independent of disease stage;
- Ready accessibility of post-exposure prophylaxis (PEP) through SF City Clinic (the City's STI clinic) and early adoption of pre-exposure prophylaxis (PrEP) in San Francisco;
- The EMA's ongoing commitment to community engagement in citywide planning as well as at the level of service provision; and
- The HIV Prevention Planning Council's (HPPC's) consistent recommendation that funding be allocated based on the local epidemiology

**2.B.3) Signi icant Health Disparities Revealed Through the Continuum and Responses:** While the initial Consortium of Care chart did not reveal new disparities, it confirmed the persistence of some known disparities and identified issues in the countywide reporting systems and capacity that will require collaborative responses to address. The San Francisco HIV Health Services Planning Council will utilize FY 2016 Part A resources in part to continue a collaborative effort with other public and private entities to

attempt to generate a truly **integrated** continuum of HIV care in the SF EMA. "Integration" in terms of HIV means that that individuals **get** what they need, when they need it, with respect to their health. In many cases, achieving this goal requires significant transformations in systems, structures, and operations. A few examples of prioritized integration efforts for SFDPH which will be supported by the FY 2016 award are as follows:

- Efforts toward integrated HIV prevention and care community planning.
- Scale-up and integration of hepatitis C testing, linkage, and treatment into HIV and other services, including addressing the challenges of access to treatment due to its high cost; efforts also include a viral hepatitis social marketing campaign and the hiring of a Viral Hepatitis Coordinator.
- Training on integrated models for substance use, HIV, and hepatitis C to be provided by AETC.
- Integration of HIV prevention with broader, population-specific, culturally competent health and social services, an approach that is particularly important for the **transgender community**. The SF Transgender Advisory Group recommends "one-stop shopping" for services ranging from trans-specific substance use/mental health services to education and employment assistance to primary care services, with a focus on health and wellness, and not specifically on HIV.
- Increased coordination and collaboration with non-HIV health promotion efforts, including structural interventions to address alcohol use and cardiovascular disease prevention to improve overall health outcomes.
- Identification, expansion, and replication of effective best practices, such as the HIV & Integrated Services program (formerly Forensic AIDS Project) operating in the SF jail system. In collaboration with SFDPH STD Prevention & Control Program, the Linkages to Health Education and Prevention (LHEAP) team offers HIV, STI and hepatitis C testing to SF residents upon entry into the SF county jails. Last year alone, over **3,000** people were tested for HIV and **24** positives were identified of **12** which were new diagnoses. **Ten** of the newly diagnosed (**83%**) and **7** of the known HIV-positive individuals (**58%**) were linked to care. In addition, overdose prevention is integrated with these other services. In 2012, the LHEAP team in collaboration with the DOPE Project implemented a pilot project to make the naloxone nasal spray available upon release to individuals who participate in a brief training.

**Figure 5** below provides a schematic view of the EMA's vision of developing goals and achieving objectives of an integrated continuum of care. It is important to note that service integration may offer some solutions to challenges that HIV prevention has long faced. Historically, HIV prevention has been asked to fund services for populations at high risk for a variety of health issues, even though risk for HIV may be low. For example, it is not uncommon to hear that services for non-MSM populations, such as HIV-negative women and non-MSM youth, are insufficient. Integration offers opportunities to fund services appropriately, while also meeting the need (e.g., integrating HIV prevention messages into homeless services at low or no cost). The HIV prevention and sexual health needs in Bayview/Hunters Point, which is home to many HIV care and treatment services but few HIV prevention services, can potentially be addressed by leveraging non-HIV-related efforts and broader health initiatives (e.g., SFDPH's Black/African American Health Initiative). Finally, in the process of "getting to zero," the target population will be harder

and harder to reach. Integrated services where HIV is not the focus might attract clients that we haven't been able to reach in any other way.

**Figure 5. Sample San Francisco EMA Integrated HIV Prevention & Care Goals**

| Goals | Indicators | Data | Overall Trend |
|---|---|---|---|
| Reduce new HIV infections | *New diagnoses* | 2011: 510<br>2012: 495<br>2013: 418<br><br>*SF, San Mateo, and Marin. Source: County HIV surveillance data.* |  |
| | *Estimated % of MSM in SF who are unaware of their HIV-positive status* | 2005: 23%<br>2008: 17%<br>2011: 6%<br><br>*SF only. Source: NHBS.* |  |
| Increase access to care and improve health outcomes for PLWH | *Linkage to care* | 2011: 84%<br>2012: 86%<br>2013: 89%<br><br>*SF and Marin only. SF data is linkage to care within 3 months. Marin data is linkage to care within 6 months. Source: County HIV surveillance data.* |  |
| | *Late diagnosis* | 2010: 26%<br>2011: 24%<br>2012: 21%<br><br>*SF only. Data represents the proportion of new HIV diagnoses that developed AIDS within 3 months of diagnosis. Source: County HIV surveillance data.* |  |
| | *Viral suppression* | 2010: 56%<br>2011: 58%<br>2012: 68%<br><br>*SF only. Data represents the proportion virally suppressed within 12 months of diagnosis. Source: County HIV surveillance data.* |  |
| Reduce HIV-related disparities and health inequities | *See Exhibit 3* | |  |

**2.B.4) Unique Challenges and Responses:** In keeping with the fourth NHAS goal related to improving coordination across federal agencies and streamlining data collection, the SF EMA will take the lead on establishing a **new set of core indicators** that will be used to mark our progress toward "Getting to Zero." These indicators will be established by harmonizing data elements and definitions across the multiple requirements. (For example, instead of measuring linkage to care in several different ways, we will strive to measure it one way.) The EMA will also coordinate with local experts and federal funders to ensure that stakeholders' core needs are met and that the EMA is able to measure population-level outcomes as well as performance targets. Given limited public health resources, it is no longer feasible to continue to measure and report on the dozens if not hundreds of indicators that are requested from or required of jurisdictions by various funders and stakeholders. Instead, a core set of locally meaningful indicators is needed. Harmonization will take into account the following:

- Institute of Medicine (IOM) indicators (http://www.iom.edu/Reports/2012/Monitoring-HIV-Care-in-the-United-States.aspx)
- Common indicators for Department of Health and Human Services (DHHS)-funded programs and services (http://aids.gov/pdf/hhs-common-hiv-indicators.pdf)
- HIV headline indicators for the SFDPH Population Health Division
- HPPC Measurements of Success
- HIV Prevention Section 2010 Request for Proposals (RFP) goals and outcomes and agency performance targets
- PS12-1201 funding opportunity announcement (FOA) objectives
- PS12-1201 Comprehensive Plan goals and targets
- Enhanced Comprehensive HIV Prevention Planning (ECHPP) goals and objectives
- Health Services and Resources Administration (HRSA) HIV/AIDS Bureau (HAB) and other Ryan White CARE Act indicators
- SFDPH Primary Care Continuous Quality Improvement measures
- Spectrum of engagement in care indicators

## 3) DEMONSTRATED NEED

### 3.A) Early Identi ication of Individuals with HIV/AIDS (EIIHA)

**"I love the San Francisco model. If it keeps doing what it is doing, I have a strong feeling that they will be successful at ending the epidemic as we know it. Not every last case - we'll never get there - but the overall epidemic. And then there's no excuse for everyone not doing it."**

**- Dr. Anthony S. Fauci**
**Director, National Institute of Allergy and Infectious Diseases**
***New York Times*, October 5, 2015[3]**

### 3.A.1) Required HIV Testing Data - See Figures 6 & 7 below

| Figure 6. Chart A. San Francisco EMA Newly Diagnosed HIV Test Events January 1 - June 30, 2015 | | | |
|---|---|---|---|
| **Data Elements** | **MSM[1]** | **IDU** | **MTF/M** |
| ▪ Number of test events | **9,801** | **524** | **380** |
| ▪ Number of newly diagnosed positive test events | **77** | **0** | **4** |
| ▪ Number of newly diagnosed positive test events with client linked to medical care | **51*** | **NA** | **0*** |
| ▪ Number of newly diagnosed confirmed positive test events | **75** | **0** | **4** |
| ▪ Number of newly diagnosed confirmed positive test events with client interviewed for Partner Services | **58*** | **NA** | **3*** |
| ▪ Number of newly diagnosed confirmed positive test events with clients referred to prevention services | **68*** | **NA** | **2*** |
| ▪ Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing | **51*** | **NA** | **0*** |

| Figure 7. Chart B. San Francisco EMA Previously Diagnosed HIV Test Events January 1 - June 30, 2015 | | | |
|---|---|---|---|
| **Data Elements** | **MSM[1]** | **IDU** | **MTF/M** |
| ▪ Number of test events | **9,801** | **524** | **380** |
| ▪ Number of previously diagnosed positive test events | **5** | **0** | **1** |
| ▪ Number of previously diagnosed positive test events with client re-engaged in HIV medical care | **1*** | **NA** | **0*** |
| ▪ Number of previously diagnosed confirmed positive test events | **3** | **0** | **0** |

| Figure 7. Chart B. San Francisco EMA Previously Diagnosed HIV Test Events January 1 - June 30, 2015 | | | |
|---|---|---|---|
| **Data Elements** | **MSM[1]** | **IDU** | **MTF/M** |
| ▪ Number of previously diagnosed confirmed positive test events with client interviewed for Partner Services | **3*** | **NA** | **0*** |
| ▪ Number of previously diagnosed confirmed positive test events with clients referred to prevention services | **3*** | **NA** | **0*** |
| ▪ Number of previously diagnosed confirmed positive test events linked to and accessed CD4 cell count and viral load testing | **1*** | **NA** | **0*** |

[1] MSM also includes those identified as MSM/IDU.
*Follow-up data for positives is incomplete

### 3.A.2) FY 2016 EIIHA Plan

### 3.A.2.a) Planned Activities of the San Francisco EMA EIIHA Plan for FY 2016

Estimate of HIV-Positive Individuals Who Are Unaware of Their Serostatus: **The San Francisco EMA has solid indications that it has achieved an unprecedented level of success in reducing the number of persons with HIV in the EMA who are unaware of their serostatus.** Two years ago, the EMA estimated that a total of **3,339** individuals were infected with HIV but unaware of their serostatus as of the end of 2012, representing **14.4%** of all persons 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 scienti ic advances, has now led to the lowest rate of undiagnosed HIV infection in the nation, currently estimated at only 6.4%, with viral load suppression rates that far surpass the national average (68% in SF vs. 25% nationally).**[4] This means that only **1,021** HIV-infected and unaware persons are now estimated to be living in the San Francisco EMA as of December 31, 2014 out of a total of **15,955** confirmed HIV cases.

Target Populations for FY 2016 EIIHA Plan: To define and focus EIIHA activities, the following **three** populations will continue to serve as the key target groups for the FY 2016 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 2016 EIIHA Plan will encompass **three** broad activity areas which mirror those of the three succeeding EIIHA plans. The first area involves continuing to identify individuals who are unaware of their HIV status and providing high-quality rapid testing and acute RNA pooled screening for most MSM. San Francisco has implemented rapid 4th generation combination antibody / antigen (Ab/Ag) tests at sites that do not currently have access to pooled RNA testing. The 4th generation rapid testing identifies not only HIV antibodies but also HIV-1 p24 antigens, which in turn allows for the immediate identification and rapid treatment of acute HIV-1 infection. 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 lead not only to missed HIV diagnoses but to lost opportunities to intervene with treatment and counseling at the time when an individual is at greatest risk 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 **20 minutes.**

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.

A third key activity aims to ensure that pre-exposure prophylaxis (PrEP) is continually woven into the HIV testing process. The EMA has developed a PrEP training program specifically for our HIV prevention staff which details how to provide health education information regarding PrEP to clients and how to work with clients in accessing PrEP treatment. The primary goal of this training is to promote and facilitate ever-widening utilization of PrEP throughout the EMA.

**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 originally 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 (see below).

Although not required by HRSA, in San Francisco, the HIV Health Services Planning Council coordinates Part B services in conjunction with Part A services to maximize the impact of these two funding streams. This service planning process is in turn coordinated with all relevant County units, 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 the 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 soon to be merged San Francisco HIV Health Services Planning Council and HIV Prevention Planning Council – help develop and enhance HIV access across systems and ensure 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 2016 EIIHA Plan:** The FY 2016 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; **2)** to increase the number of HIV-positive individuals in our region who are effectively engaged in HIV care; and **3)** 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 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. These groups have been engaged in service planning for PrEP as well. 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.

**3.A.2.b) How the FY 2016 Plan Contributes to the Goals of the National HIV/AIDS Strategy:** The goals and objectives of the proposed FY 2016 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.[5] The 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.

**3.A.2.c) How the FY 2016 Plan Contributes to the Goals of the White House Continuum of Care Initiative:** The San Francisco EMA fully supports both the goals and the approach of the White House's HIV Care Continuum Initiative, as outlined in the Office of National AIDS Policy's report entitled *Improving Outcomes: Accelerating Progress Along the HIV Care Continuum.*[6] The EMA's Part A and EIIHA priorities and activities are fully aligned with the goals outlined in the initiative, including: a) lowering the number of new HIV infections by 25%; b) increasing the percentage of people living with HIV who know their serostatus to 90%; c) reducing the HIV transmission rate by 30%; d) increasing the percentage of persons diagnosed with HIV who are linked to HIV medical care within 3 months after diagnosis to 85%; e) increasing the percentage of Ryan White program clients in continuous care to 80%; f) increasing the percentage of Ryan White clients with permanent housing to 86%; and g) and increasing the percentage of HIV-diagnosed MSM, African-Americans, and Latinos with a suppressed viral load by at least 20%. The EMA strives to foster and expand integrated systems that link HIV identification, care engagement, and care and treatment retention while continually expanding the system's capacity to accurately monitor these activities in order to identify and address gaps and disparities.

**Innovative Approaches:** San Francisco brought about a major enhancement of its HIV testing services matrix this year by implementing the new **Linkage Integration Navigation Comprehensive Services (LINCS) program,** a highly effective intervention designed to increase the number of HIV-infected individuals who are effectively linked to and anchored in care. The LINCS Team provides a comprehensive range of services based on individual client needs and circumstances, incorporating linkage to HIV medical care, social services, partner services, and retention services under a single umbrella. LINCS

employs an integrated team of **ive full-time staff.** Three of these staff provide individualized, tailored care linkage and retention services and centralized access to services for the majority of persons testing newly positive in San Francisco. Two staff members are based at high-volume citywide testing sites such as San Francisco's nationally recognized Magnet Clinic and the UCSF Alliance Health Project while a third "rover" serves lower-volume community-based testing and medical sites. These LINCS Team members are directly paired with newly identified HIV-positive individuals and remain paired in a supportive relationship for up to **three months** following initial HIV diagnosis. The program strives to ensure: 1) that linkage to care is made **within 30 days** for **everyone** testing positive in San Francisco; and 2) that **all** newly-diagnosed individuals are offered comprehensive and immediate linkage and partner services. An additional two LINCS staff focus on providing navigation services to long-term HIV-positive clients who are at risk for falling out of care or are out of care, with a goal of ensuring that **no one** falls out of care, and if they do, that they are re-engaged with care as quickly as possible. In 2012-13, LINCS navigators searched for **315** missing HIV patients and succeeded in enrolling **116** of them - the rest were not found or were jailed, dead, or refused help. More significantly, **73%** of LINCS patients remained in care and were **twice as likely** to be virally suppressed as comparable patients who were not in LINCS.

The LINCS Team also plays a critical role in facilitating identification of new persons with HIV by taking a leading role in **partner services (PS)** in the region. Formerly, when individuals in the EMA tested positive, they were given the option of speaking to a Health Department staff person regarding the PS program, an option that often was not chosen. Under the new system, however, each LINCS team member directly offers partner services during the **initial** client encounter, with clients **strongly encouraged** to participate in the program. Additionally, because each LINCS Team member serves as both DPH linkage specialist and partner services representative, the PS message can be reinforced over time through contact with an individual the clients come to know and trust. In order to expand the broadened partner services program to private care providers, the SF Department of Public Health maintains memoranda of understanding (MOUs) with at least **10** private physicians in the City who serve a high proportion of HIV patients to refer clients for partner services. The incorporation of partner services into the LINCS Team model is expected to significantly increase the number of new HIV positive individuals identified in the San Francisco region.

San Francisco has also introduced the highly influential and impactful **Rapid Antiretroviral Program Initiative for New Diagnosis (RAPID),** a program that has been in place at San Francisco General Hospital for just over a year. RAPID is a comprehensive initiative designed to help clients overcome the financial and social barriers to undergoing testing for HIV and being linked to care.[7] RAPID provides **same-day linkage to care** for all newly diagnosed HIV patients who are initiating care at **Ward 86** - the city's massive public HIV clinic based at San Francisco General Hospital - with a focus on **initiating immediate ART treatment** for these individuals. Five day "treatment packs" are dispensed to new clients entering the clinic on the **same day** they have received an HIV diagnosis and a full set of labs are drawn and the patient meets with a social worker to ensure coverage for the continuance of the ART medications. RAPID not only promotes patient health through early engagement in treatment, but plays a significant role in preventing new infections by reducing infectivity when patients are experiencing acute HIV syndrome, during which

they are at greatest risk to pass the virus on to others. The RAPID program is able to provide immediate medication linkage for clients linked at HIV testing sites throughout San Francisco, and has been extremely effective in helping the city meet its long term test and treat goals.

San Francisco has also vigorously embraced **pre-exposure prophylaxis (PrEP)** as an effective approach to reducing new infections among high-risk individuals in the EMA, with a particular emphasis on MSM in the City of San Francisco. San Francisco has become known as the premier hub of PrEP use worldwide, with San Francisco chosen as one of 2 US sites for the global iPrEx study of once-daily Truvada use for gay men, and with the city establishing the nation's first PrEP demonstration project.[8] The San Francisco Health Network has trained its primary care providers to prescribe and administer PrEP and it is now at the Network's **14** neighborhood clinics and will soon be available through the Ward 86 HIV Clinic at San Francisco General Hospital (SFGH). The San Francisco Department of Health (SFDPH) has allocated **$1.1M** in general funds in the current fiscal year to provide PrEP services and patient navigation and to support the rapid HIV treatment program at SFHG. The San Francisco Health Network has also recently hired a **full-time PrEP Navigator** assist patients and service providers to inform, prescribe, and bill for PrEP treatment. San Francisco Board of Supervisors member David Campos has earmarked **$310,000** for two additional navigators to expand access to PrEP through existing channels including Medicaid, Medicare, private insurance and Gilead's Patient assistance Program. SFDPH also recently received a grant from CDC to provide PrEP counseling, outreach and linkage to MSM and transgender women of color and has submitted a grant application to the California HIV/AIDS Research Program to provide PrEP to transgender women with a special focus on transgender women of color. While SFDPH does not at this time have systems in place to examine PrEP utilization system-wide, the San Francisco **Magnet Clinic**, a major gay men's health and wellness center storefront in the city's Castro District already has more than **6,000** clients on PrEP and is starting at least **25** new clients a week on PrEP treatment, with a two week wait list for PrEP interviews. Additionally, the University of California San Francisco recently received a CDC grant to operate **PrEPline**, a telephone consultation service to provide expert guidance to healthcare providers across the nation who wish to provide PrEP.

**Key Collaborations:** Key collaborations related to the HIV continuum of care in San Francisco include the active partnership that exists between the three regions that make up the San Francisco EMA as well as between the region's HIV care and planning councils – two structures that will soon be merged in order to facilitate greater integration and collaboration. San Francisco has also fully embraced the UNAIDS **Getting to Zero** model made as an effectively structure for building on the city's already strong test and treat efforts. San Francisco's Getting to Zero initiative operates as a **multi-sector independent consortium** operating under the principles of **collective impact**. Modeled after the UNAIDS goals, the initiative's vision is to reduce HIV transmission and HIV-related deaths in San Francisco by **90%** before 2020. The San Francisco Getting to Zero initiative is a **volunteer-led effort** that involves the broadest possible range of public and private sector agencies, service providers, consumers, and planners. The initiative is committed to maintaining current funding levels for HIV prevention and treatment; avoiding competition for new funding through Getting to Zero efforts; and prioritizing underserved populations. Goals of the Getting to Zero initiative are established and prioritized in **working**

**committees** with efforts based on measurable objectives and plans, including budgets, for implementation.

**Use of EIIHA Data to Analyze and Address Continuum Gaps:** The San Francisco EMA has pioneered the use of detailed HIV surveillance data to better identify populations who are not linked to HIV care or are falling out of care, with the objective of permanently linking or re-linking these individuals to comprehensive HIV services. Several years ago, San Francisco developed a highly influential set of 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. These efforts were instrumental in helping the city develop new strategies for better targeting outreach and prevention efforts on those neighborhoods whose residents were least likely to know their HIV status or to be in care. The EMA has consistently expanded and built upon these approaches and is now able to harness client-level data information to the work of the city's LINCS team in order to continually identify and link or re-link to care persons with HIV who are not currently served by the system, with the eventual goal of eliminating health outcome disparities in regard to HIV.

**3.A.2.d) Relationship to Unmet Need Estimate and Activities:** The FY 2016 EIIHA Plan responds to the EMA's annual unmet need process both prospectively and retrospectively. In a prospective sense, the EIIHA Plan seeks to **continue to decrease the number of persons living with HIV/AIDS in the region who are unaware of their HIV status.** Through our highly successful, multi-partner based Getting to Zero initiative, the EMA has already achieved unprecedented success in reaching a region-wide HIV unaware percentage of only **6.5%** - a percentage that already far exceeds the national HIV Continuum Initiative goal of at least **10%** unaware. However, as the EMA achieves greater success, it also becomes increasingly difficult to identify undiagnosed infected individuals, requiring new and innovative approaches to seek out the small remaining pockets of undiagnosed infection. 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.

**3.A.2.e) How the FY 2015 EIIHA Plan In luenced the FY 2016 Plan:** A key facet of the EMAEIIHA plan is that it is **highly lexible** 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 2015 Plan have proved successful in reducing undiagnosed infection and improving linkage to care, so these models will continue. The EMA will continue to develop and implement out partnership-based interventions that enhance early intervention, including the expanded use of pre-exposure prophylaxis (PrEP), rapid linkage to care, and widespread use of rapid 4th generation rapid antigen /antibody testing.

**3.A.2.f) Planned Efforts to Remove Legal Barriers:** Opt-out testing is now routine in the EMA with **no** barriers. This year , the EMA was informed that client-level information related to linkage and partner services **could** be shared with other local health jurisdictions with no violation of State privacy laws, removing the final remaining barrier to being able to effectively track and identify persons with HIV who move among different jurisdictions. With this final issue resolved, our ability to track, monitor, and enhance testing and care across our three counties will increase dramatically, in turn producing even more enhanced outcomes in terms of identification, linkage to, and retention in care.

**3.A.2.g) FY 2016 Target Populations:** As noted above the three EIIHA target populations for FY 2016 are: **1) Males Who Have Sex with Males (MSM); 2) People Who Inject Drugs (PWID); and 3) Transgender Females Who Have Sex with Males (TGF/M).**

**Why Target Populations Were Chosen:** The San Francisco EMA's FY 2016 EIIHA target populations have been selected on the basis of **three** key factors. **First**, from an epidemiological standpoint, these three populations together encompass nearly **95%** of all persons currently living with HIV/AIDS in the San Francisco EMA. MSM alone – including MSM who inject drugs – make up **85.8%** of all persons living with HIV/AIDS cases in the region as of December 31, 2014, while non-MSM IDU make up another **6.6%** 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).

**Speci ic Challenges within the Target Populations:** While the prevention paradigm of broadly based viral load suppression holds out the probability of dramatically reduced rates of new HIV infections, additional challenges emerge that are equally salient. For example, 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 structural guidance for full implementation to be effective.

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 to test for HIV every 3 to 6 months with members of highest behavioral risk populations? Additional questions include: How will our ability to detect acute HIV more systematically as new technologies emerge, combined with the local universal offers of ARV treatment independent of HIV disease stage, impact system capacity? And as more persons with HIV are identified, how to ensure that these individuals are linked to care and do not fall through the cracks, particularly in light of critical co-factors such as poverty, discrimination, and mental health and substance use issues? 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 challenges such as the following 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; d) fear of deportation among undocumented immigrants; and e) substance use behaviors that hinder self efficacy to access and system limitations

that may inadvertently impede HIV testing. One challenge particular to San Mateo and Marin Counties involves the difficulty in accessing HIV-risk MSM due to the lack of gay-specific venues or hangouts in those areas.

Key **cultural issues** impacting HIV awareness in San Francisco include: a) the dual discrimination faced by many MSM of color in regard to sexual orientation and racial/ethnic background; b) the 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 care and service systems; e) fear of discrimination based on race/ethnicity within HIV service agencies; f) the shortage of culturally specific and multilingual drug treatment programs for persons of color; and g) the still insufficient number of programs that effectively address key issues underlying HIV risk behaviors and unwillingness to seek testing, such as persistent poverty, institutionalized discrimination, and childhood abuse and exposure to trauma.

**Speci ic 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 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 2016 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 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. This program was 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.

**SMART Objectives for Each Target Population:**

- **MSM:**

1. Between March 1, 2016 and February 28, 2017, to provide a total of at least **19,000** documented HIV antibody tests for MSM in the San Francisco EMA.
2. Between March 1, 2016 and February 28, 2017, to identify a total of at least **290** new or previously diagnosed HIV-positive individuals within this population.
3. Between March 1, 2016 and February 28, 2017, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.

4. Between March 1, 2016 and February 28, 2017, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
5. Between March 1, 2016 and February 28, 2017, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
6. Between March 1, 2016 and February 28, 2017, ensure that at least **75%** accept partner services.

- **IDU:**

7. Between March 1, 2016 and February 28, 2017, to provide a total of at least **1,750** documented HIV antibody tests for IDU in the San Francisco EMA.
8. Between March 1, 2016 and February 28, 2017, to identify a total of at least **35** new or previously diagnosed HIV-positive individuals within this population.
9. Between March 1, 2016 and February 28, 2017, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
10. Between March 1, 2016 and February 28, 2017, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
11. Between March 1, 2016 and February 28, 2017, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
12. Between March 1, 2016 and February 28, 2017, ensure that at least **75%** accept partner services.

- **Transgender Women Who Have Sex with Men:**

13. Between March 1, 2016 and February 28, 2017, 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.
14. Between March 1, 2016 and February 28, 2017, to identify a total of at least **11** new or previously diagnosed HIV-positive individuals within this population.
15. Between March 1, 2016 and February 28, 2017, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
16. Between March 1, 2016 and February 28, 2017, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
17. Between March 1, 2016 and February 28, 2017, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
18. Between March 1, 2016 and February 28, 2017, ensure that at least **75%** accept partner services.

**Responsible Parties and Collaborations:** Implementation and evaluation of the FY 2016 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, will regularly report this information to the State of California, and will summarize the data in regular reports to HRSA as required

**Planned Outcomes:** The proposed FY 2016 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.

**3.A.2.h) Plan to Disseminate EIIHA Plan and Outcomes:** As a document that is jointly developed by HIV Health Services and the Community Health Equity and Promotion Branch, the FY 2016 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, two bodies that are expected to merge within the next 12 months in order to facilitate integrated planning. 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.

## 3.B) UNMET NEED

**3.B.1) Unmet Need Frameworks** - See **Tables** in **Attachment 4**

**3.B.2) Changes in Unmet Need Percentage** - See **Tables** and **Narrative in Attachment 4**

## 3.C) SERVICE GAPS

**3.C.1) Gaps Within the Jurisdiction:** The chart below compares the population of PLWHA enrolled in the San Francisco EMA Ryan White system of care for FY 2015 with the EMA's combined PLWHA population as of 12/31/14 (see **Figure 8**)

**Figure 8. Comparison of San Francisco EMA Ryan White Clients with Overall PLWHA Population**

| Demographic Group / Exposure Category | Total Unduplicated Clients Enrolled in Ryan White Services - 3/1/14 - 2/28/15 | | Combined SF EMA PLWHA Population as of 12/31/14 | | Population Variances |
|---|---|---|---|---|---|
| **Race/Ethnicity** | | | | | |
| African American | 1,348 | 20.7% | 2,070 | 13.0% | + 7.7% |
| Latino / Hispanic | 1,375 | 21.1% | 3,169 | 19.0% | + 2.1% |
| Asian / Pacific Islander | 382 | 5.9% | 986 | 6.2% | - 0.3% |
| White (not Hispanic) | 2,835 | 43.6% | 9,257 | 58.0% | - 14.4% |
| Other / Multiethnic / Unknown | 563 | 8.7% | 473 | 3.0% | + 5.7% |

| Demographic Group / Exposure Category | Total Unduplicated Clients Enrolled in Ryan White Services - 3/1/14 - 2/28/15 | | Combined SF EMA PLWHA Population as of 12/31/14 | | Population Variances |
|---|---|---|---|---|---|
| | 6,503 | 100% | 15,955 | 100% | |
| **Gender** | | | | | |
| Female | 782 | 12.0% | 1,054 | 6.6% | + 5.4% |
| Male | 5,505 | 84.7% | 14,525 | 91.0% | - 6.3% |
| Transgender | 211 | 3.2% | 376 | 2.4% | + 0.8% |
| | 6,503 | 100% | 15,955 | 100% | |
| **Age** | | | | | |
| 0 - 24 Years | 105 | 1.6% | 176 | 1.1% | + 0.5% |
| 25 - 44 Years | 1,865 | 28.7% | 5,009 | 31.4% | - 2.7% |
| 45 - 54 Years | 2,370 | 36.4% | 5,967 | 37.4% | - 1.0% |
| 55 - 64 Years | 1,683 | 25.9% | 3,590 | 22.5% | + 3.4% |
| 65 Years and Above | 480 | 7.4% | 1,213 | 7.6% | - 0.2% |
| | 6,503 | 100% | 15,955 | 100% | |
| **Transmission Categories** | | | | | |
| MSM | 3,578 | 55.0% | 11,436 | 71.7% | - 16.7% |
| Injection Drug Users | 708 | 10.9% | 1,052 | 6.6% | + 3.3% |
| MSM Who Inject Drugs | 628 | 9.7% | 2,251 | 14.1% | - 4.4% |
| Heterosexuals | 464 | 7.1% | 712 | 4.5% | + 1.6% |
| Other | 168 | 2.6% | 59 | 0.4% | + 2.2% |
| Unknown | 957 | 14.7% | 445 | 2.8% | + 11.9% |
| **TOTAL** | **6,503** | **100%** | **15,955** | **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 **12.0%** of all Ryan White clients as of February 28, 2015 (n=**1,054**). Meanwhile, while whites make up **58.0%** of all PLWHA in the EMA, they comprise only **43.6%** of Ryan White clients as of the same date (n=**2,835**). 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 **20.7%** of Ryan White clients in the San Francisco EMA are African American (n=**1,348**) despite the fact that they comprise **13.0%** 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.[9] Women, representing **6.6%** of the total PLWHA population, make up **21.7%** of all Centers of Excellence clients. Transgendered people

make up **3.2%** of persons served through the Ryan White system and **5.4%** of persons served through Centers of Excellence, while making up **2.4%** 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.**

Additionally, 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. [10] 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.

**3.C.2)** **Methods to Prioritize Service Gaps:** The San Francisco HIV Health Services Planning Council uses a broad range of methods to identify and prioritize service needs and gaps in the San Francisco EMA. As noted in the Description of the Community Input Process below, this includes a detailed analysis of each priority service category funded and not funded by the Council in FY 2015 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, 2014 through February 28, 2015, 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 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; 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 PLWHA.

**3.C.3)** **Addressing Service Gaps Through Part A Funding:** 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.

### 3.D) Minority AIDS Initiative

**3.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.

**3.D.2) Description of MAI-Funded Activities:** 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 2014 alone, Latino/a PLWHA in the EMA grew from **15.5%** to **19.9%** of total PLWHA. 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.[11] 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 counseling 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.D.3) Impact of MAI Programs:** 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 providing critical medical, case management, and primary services to **over 320** impoverished clients of color, many of whom are transgender persons.

### 3.E) Special Populations and Complexity of Providing Care

**3.E.1) Emerging Communities:** No new or emerging populations experienced significant changes in service delivery in the EMA during the past year.

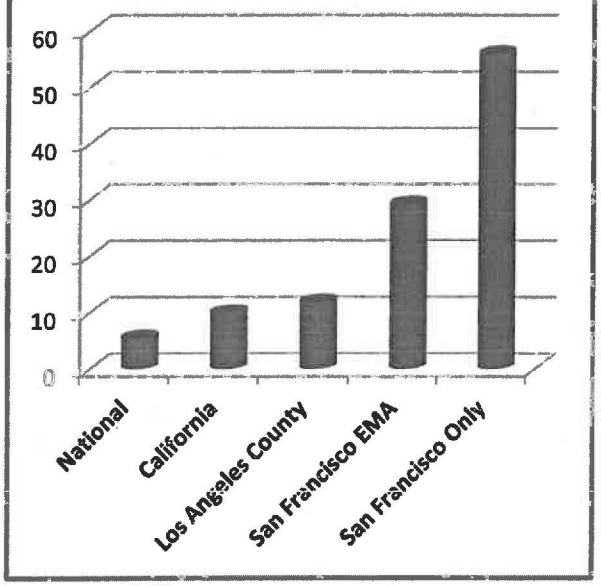
**3.E.2) Under-Represented Populations:** As noted in the Service Gaps section immediately above, **whites, men,** and **MSM** are underrepresented in the San Francisco Part A system due largely to the fact that their higher average incomes and higher rates of private insurance reduce their need to rely on Ryan White-funded care. Ryan White clinics provide primary medical care to disadvantaged, underserved, and underprivileged populations such as persons of color, women, persons with low incomes, the homeless, heterosexuals, and injection drug users. These individuals have been the specific target of Part A outreach and services not only because of growing HIV caseloads, but because of the disproportionate toll that HIV takes on these populations in terms of factors such as care linkage, medication adherence, and poorer long term health outcomes. For example, according to the San Francisco HIV Epidemiology Section, African American males experienced the highest HIV mortality rates in San Francisco from 2002 to 2012 as compared to all other racial and ethnic groups, with the 2012 mortality rate among HIV-infected African American men being **2.1 times higher** than that of white men with HIV and **3.2 times higher** than Latino men with HIV.[12] African American women with HIV had even higher mortality disparities, dying at a rate **9.4 times higher** than white women.[13] In addition, in 2013, lower proportions of women, transgender women (transwomen), African Americans, and persons who inject drugs were linked to and retained in care and achieved viral suppression as compared to other populations.[14]

**3.E.3) Co-Morbidities Table** - See **Attachment 5**

**3.E.4) Co-Morbidities and Co-Factors Narrative**

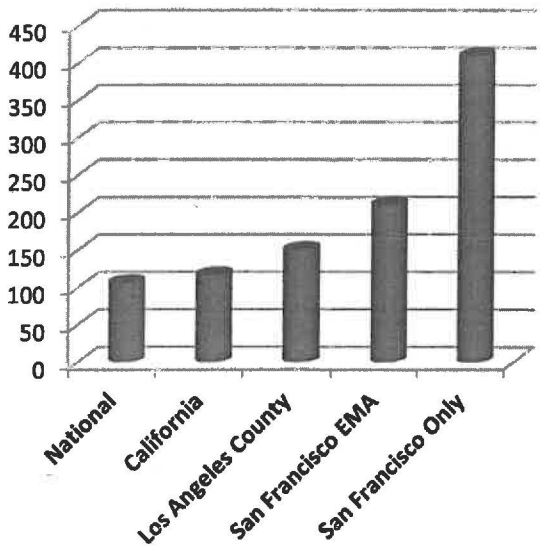
**Sexually Transmitted Infection (STI) Rates:** The growing crisis of **sexually transmitted infections** is of significant concern for the future of the HIV epidemic in our region. In terms of **syphilis,** for example, the San Francisco EMA continues to confront a **major epidemic** that has been escalating for the past half-decade, rising **more than 500%** since 2000. In CY 2014, a total of **518** new primary and

**Figure 9. New Primary & Secondary Syphilis Cases Per 100,000 Popula on - Selected Metropolitan Areas, 2014**



secondary syphilis cases were diagnosed in the EMA, representing a **126% increase** over the **229** cases reported just six years earlier in 2007.[15] The combined EMA-wide syphilis rate of **29.2** per 100,000 in 2014 is **nearly three times** the statewide rate of **9.9.** Within the City of San Francisco alone, a total of **450** new syphilis cases were reported in 2014 for a very high incidence rate of **55.9** cases per 100,000, a rate **ive times higher** than the statewide rate and **nearly ten times higher** than the national syphilis rate of **5.5** cases per 100,000 in 2013 (see **Figure 9**). **San Francisco County has by far the largest syphilis infection rate of any county in California,** nearly **three times** the rate of the second highest county, Kings County (**16.2** per 100,000) and nearly **ive times** that of Los Angeles County (**11.8** per 100,000).[16]

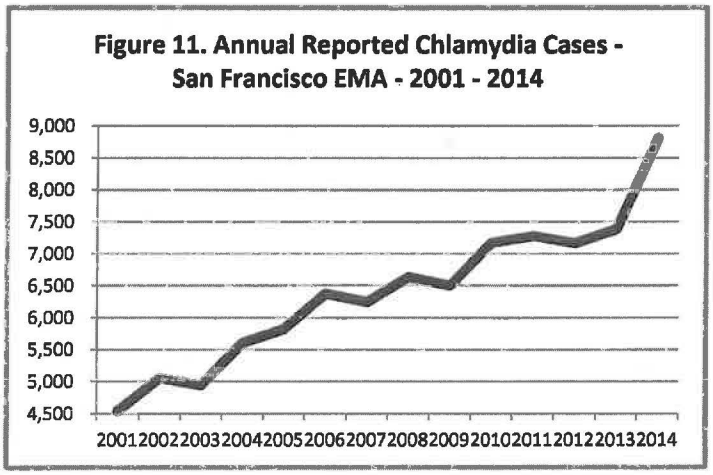
**Figure 10. New Gonorrhea Cases Per 100,000 Popula on - Selected Metropolitan Areas, 2014**




The EMA is also experiencing a significant **gonorrhea** epidemic. A total of **3,736** new gonorrhea cases were identified in the San Francisco EMA in 2014, for an EMA-wide incidence of **210.4** cases per 100,000, a rate that is **80% higher** the 2014 California rate of **116.8** cases per 100,000.[17] [18] The number of new gonorrhea cases in the city of San Francisco increased by **70%** between 2010 and 2014 alone, growing from **1,927** reported cases in 2010 to **3,293** cases in 2014. The city of San Francisco's 2014 gonorrhea incidence of **409.0** per 100,000 is **nearly three times** the national rate of **106.1** cases per 100,000 and **more than three times higher** than the State of California as a whole (**116.8**); this is again by **far the highest rate of any county in California**, with the next highest county – Shasta County - having a case rate of **211.2** per 100,000 (see **Figure 10**).[19]

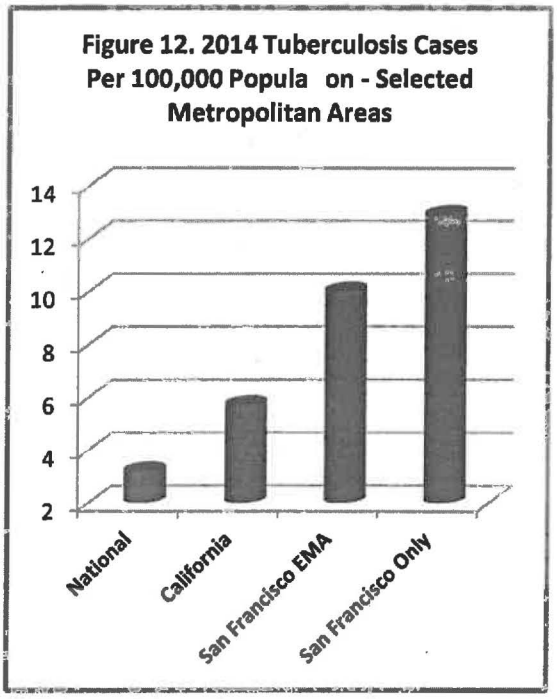
The San Francisco EMA's **Chlamydia** epidemic also continues to rise precipitously. A total of **8,801** new cases of Chlamydia were diagnosed in the San Francisco EMA in 2014. This represents a **51.3% increase** over the **5,816** cases diagnosed in 2005 and a **78.2% increase** since 2001 (see **Figure 11**).[20] The 2014 EMA-wide Chlamydia incidence stood at **495.5** per 100,000, while the rate for the City of San Francisco was **742.9** cases per 100,000. By comparison, the 2014 incidence for California was **453.4** cases per 100,000 while the national rate

**Figure 11. Annual Reported Chlamydia Cases - San Francisco EMA - 2001 - 2014**



was **444.6.**[21]

**The cost of treating STIs adds signi icantly 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.**[22] 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.[23] 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.**[24] Such studies suggest that the total cost of treating new STIs in the SF EMA may be as high as **$8.7 million** per year, including an estimated **$2.0 million** to treat STIs among persons with HIV and 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.[25]




**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 **197** new cases of TB diagnosed in the SF Metropolitan Area in 2014, representing an EMA-wide incidence of **11.1** cases per 100,000.[26] In San Francisco, the incidence is even higher, at **14.2** cases per 100,000. San Francisco County's 2014 TB rate ranked **second** out of 58 counties in California, while San Mateo ranked **third. San Francisco's TB incidence rate is more than double the statewide rate of 5.6 cases per 100,000 and nearly four times higher than the national rate of 3.0 cases per 100,000** (see **Figure 12**).[27] 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.[28]

The growing local epidemic of **hepatitis C** also 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.** In 2011 alone - the last date for which statistics are available - a total of **2,136** cases of hepatitis C were identified in the San Francisco EMA, for a region-wide incidence of **120.3** per 100,000. By contrast, the statewide incidence in California in 2011 was **88.3.** 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.[29] While significant advancements have been made in hepatitis C treatment over the past two years, these treatments are extremely costly, and it is still unclear as to what extent insurers will be willing to shoulder the burden of treatment for low-income persons living with hepatitis C. At the present time, a 12-week course of Salvadi treatment costs **$84,000** while a 12-week course of Harvoni treatment is **$94,500**. 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.[30] 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.**

**Additional Co-Factors: 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 even 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.[31]

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 13**).[32]

Meanwhile, in 2015, the City of San Francisco has the **by far the highest HUD-established Fair Market Rental rate in the nation** at **$2,801** 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".[33] San Francisco's 2015 fair market rental rate of $2,801 is **nearly 50% higher** than the rate of the next highest US county, Alexandria County, VA (**$1,951**).[34]

**Figure 13.**
**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 |
| 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, 2015, the City of San Francisco conducted its bi-annual 24-hour homeless count, which identified a total of **6,686** homeless men and women living on the streets or in jails, shelters, rehabilitation centers, or other emergency facilities, a slight increase from the 2013 total of **6,436**.[35] 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.[36] Recent estimates place the number of homeless people in Marin County from as low as **1,770** to as high as **6,000**.[37] 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.**[38] 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.[39] Aging accelerates 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 **1,117** homeless individuals are estimated to be living with HIV or AIDS in the San Francisco EMA at some point each year (based on a **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.[40] 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.[41] 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 – estimates that do not take into account the higher rates of HIV infection among homeless populations.[42]

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's most recent report noted 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.[43] 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.[44] 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%.**[45] 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.[46]

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 individuals. 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.[47] 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.[48] 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.**[49] 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,[50] and recreational crystal use has been linked to **30%** of San Francisco's new HIV infections in recent years.[51]

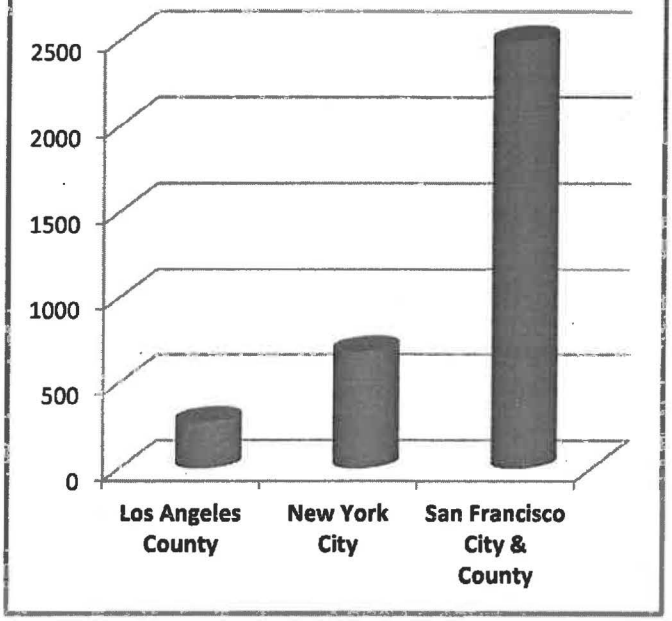
The costs associated with the substance addiction epidemic in the San Francisco EMA add significantly to the local burden of HIV care. According to the National Office on Drug Abuse (NIDA), the total costs of drug abuse and addiction due to use of tobacco, alcohol, and illegal drugs are estimated at **$524 billion** a year and illicit drug use alone accounts for **$181 billion** in health care costs, lost productivity, crime, incarceration, and drug enforcement.[52] 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.**[53] 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.[54]

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 these 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 dif icult 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 **66.2%** of all persons known to be living with HIV in the San Francisco EMA (n=**10,557**) are living at or below 300% of the 2013 Federal Poverty Level (FPL) including persons in impoverished households, while **93%** of Ryan White-funded clients live at or below 300% of poverty.[55] ARIES data reveal that as of the end of February 2015, **58.1%** of active Ryan White clients in the San Francisco are currently living at or below 100% of FPL while another **28.5%** are living between 101% and 200% of FPL. HIV-infected persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **$69 million** in Part A and non-Part A HIV-related expenditures in the San Francisco EMA each year.[56]

It is also important to note that **the City of San Francisco continues to have the largest per capita concentration of persons living with HIV of any metropolitan region in the United States.** As of the end of 2014, an estimated total of **14,408** San Franciscans were living with either diagnosed or undiagnosed HIV, representing **84.8%** of all persons living with HIV/AIDS in the EMA, for a staggering citywide prevalence of **1,789.3** cases of HIV per 100,000. **This means that 1 in every 56 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 2014, 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 14**).[57]

**Figure 14. Persons Living with AIDS Per 100,000 Popula on - Selected Metropolitan Areas**




**3.F) <u>AIDS Pharmaceutical Assistance:</u>** While the San Francisco EMA does not utilize Part A funds to administer a formal Local Pharmaceutical Assistance Program (LPAP), the County of Marin utilizes a small amount of Part A funding (**$12,000** total in FY 2015) to support a **Pharmaceutical Fund** as part of the county's Emergency Financial Assistance program. The fund is designed to help people living with HIV/AIDS pay for unexpected prescription medication emergencies. This may occur when public or private insurance will not cover a necessary prescription medication or when a person has no insurance and no alternative form of payment available for co-payments or for the full cost of prescriptions. The program is available to all who are Ryan White eligible and has a financial cap on the total amount spent for each client.

The fund cannot be used to pay for drugs that can be fully covered by ADAP, Medi-Cal, Medicare, any other or public or private health insurance program. The agency that administers the fund also provides benefits counseling and is an ADAP enrollment site. The

agency has 34 years of experience in providing HIV support services and works with local pharmacies to obtain the best possible pricing on medications. Prescriptions covered through the fund are received from the client's primary HIV care physician or from other clinicians working in close collaboration with the client's HIV provider who follow HHS HIV treatment guidelines.

Marin's HIV Care Council advises on all of Marin's HIV/AIDS Care Service categories including the Pharmaceutical Fund. The Council is made up of HIV consumers, providers, and other effected parties and has been a functioning entity since 2004. This service category has been in place for the last decade.

## METHODOLOGY

### 1) Impact of Funding

### 1.A) Impact of the Affordable Care Act

**1.A.1) Uninsured and Poverty** - Please see **Figure 15** below

**Figure 15. FY 2016 San Francisco EMA Uninsured and Poverty Data Table**
**Reporting Period: March 1, 2014 - February 28, 2015**

(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] | **5,481** | **84.3%** |
| ▪ Total persons with HIV without insurance coverage, including those without Medicaid or Medicare[2] | **1,885** | **29.0%** |
| ▪ Total persons with HIV living at or below 138% of 2014 Federal Poverty Level (FPL) | **4,700** | **72.3%** |
| ▪ Total persons with HIV living at or below 400% of 2014 FPL | **6,503** | **100.0%** |
| ▪ Percentage of FPL used to determine Ryan White eligibility in the San Francisco EMA: **≤ 400%** | | |

Source: ARIES Statistical Analysis Report (STAR), 7/27/15.
[1]Does not include persons whose insurance status is listed as "unknown" at any time within the reporting period.