APPROACHING ZERO:
SAN FRANCISCO EMA FY 2025 RYAN WHITE PART A
COMPETING CONTINUATION APPLICATION NARRATIVE

INTRODUCTION

The San Francisco (SF) Eligible Metropolitan Area (EMA) **–** encompassing Main, San Francisco, and San Mateo Counties in Northern California- requests a total **$15,705,906** in Fiscal Year 2025 Ryan White Part A Formula and Supplemental funding to continue its groundbreaking and highly effective response to the ongoing local crisis of HIV infection, including our efforts to maintain and enhance the local comprehensive model continuum of HIV care and to develop, implement, and refine innovative, effective, and collaborative models for identifying, linking, and retaining persons in HIV care. In alignment with both local and national HIV goals and initiatives, our programmatic mission is to achieve the maximum possible level of care retention and viral load suppression across **all** impacted populations and neighborhoods in our region, with the goal of making the San Francisco EMA the first metropolitan region in the United States to **effectively eliminate new infections and halt HIV disease progression**. Requested Part A funding will continue to ensure an integrated, comprehensive, and culturally competent system of care focused on reducing inequities and disparities in HIV care access and outcomes while working toward full health equity in regard to access to and utilization of HIV prevention, medical care, and support services. The FY 2025 Part A Service Plan supports an integrated continuum of intensive health and supportive services for complex, severe need, and multiply diagnosed populations that supports self-management and the personal empowerment of persons living with HIV (PLWH), including through incorporation of highly targeted funding through the Ending the HIV Epidemic (EHE) initiative. The Plan also highlights the San Francisco EMA's continually expanding syndemic-based integration of HIV care services with HIV, hepatitis, and sexually transmitted infection (STI) outreach, testing, linkage, and care retention services, while incorporating the perspectives and input of consumers, providers, and planners from across our region. The FY 2025 Part A application presents an effective strategy to preserve and advance a tradition of HIV service excellence in the San Francisco EMA while producing national model models to eliminate new HIV infections through regional care retention and viral suppression.

- **ORGANIZATIONAL INFORMATION**

A. Grant Administration

1. Program Organization:

a) Administration of Part A Funds:

The grantee agency for Ryan White Part A funds in the San Francisco EMA is the **City and County of San Francisco Department of Public Health (DPH).** Ultimate authority for the administration and expenditure of Part A funds lies with the city's **Mayor, London Breed**, and

PREVIEW Date: Oct 01, 2024 Workspace ID: WS01394483 Funding Opportunity Number: HRSA-25-054

with the city's **11-member Board of Supervisors**, which acts as both county governing board and city council for San Francisco. This authority is shared with **Grant Colfax, MD** who now serves as **Director of Public Health** for the City and County of San Francisco (see Organizational Chart in **Attachment 1**). Dr. Colfax previously served as Director of National AIDS Policy under President Obama. The administrative unit overseeing the Part A grant is **HIV Health Services (HHS)**, a section of the San Francisco Department of Public Health, Ambulatory Care Branch, overseen by **Roland Pickens,** who serves as **Director of the San Francisco Health Network** for the City and County of San Francisco**.** The **Director of HIV Health Services** is **Bill Blum, MSW,** who has served in this capacity for **12½ years**. A staff of **9 SFDPH** employees (**8.8 FTE**) - funded with differing levels of Part A support - is responsible for directing, coordinating, and monitoring the distribution and expenditure of Part A funds throughout the EMA, working a combined total of **4.89 FTE** with Part A funding. Additionally, a combined total of **1.60 FTE** of staff time is dedicated to Business and Finance Services; **0.33 FTE** to Surveillance/Epidemiology; **0.55 FTE** to Accounting Services; and **0.65 FTE** to the Contracts Administration section (see attached Budget Justification for description of individual staff roles and percentages).

San Francisco HIV Health Services works in close partnership with the **San Francisco HIV Community Planning Council**, a unified prevention and care community planning body with a maximum of **50** seats that meets monthly to oversee the prioritization, allocation, and effective utilization of Ryan White Part A funds. The HIV Community Planning Council represents the merged body of the former SF EMA HIV Health Services Planning Council and the SF HIV Prevention Planning Council. This group - whose initial meeting took place in June 2016 – has oversight responsibility for the **entire continuum of HIV prevention and care services in our region,** from outreach and testing to linkage and retention, along with all Part A-funded HIV core and support services. At the time of this writing, the Council's work is coordinated by **three Community Co-Chairs**, **Irma Parada, Richard Sullivan,** and **Zachary Davenport,** and **one Governmental Co-Chairs, Thomas Knoble.** Community Co-Chairs are elected annually for staggered terms and serve two-year terms, and also serve on the Council's **15-member Steering Committee,** which meets monthly with HIV Health Services staff to coordinate key Council activities and decision-making. Three additional standing committees support the work of the Council: **Council Affairs, Community Engagement**, and **Membership.** Administrative support for the San Francisco HIV Health Services Planning Council is provided through a subcontract to **Shanti Project**, a non-profit service organization**.** The **Director of Planning Council Support, Mark Molnar,** is a former long-term member of the SF HIV Planning Council and previously served as Co-Chair.

The two additional counties that make up the San Francisco EMA have responsibility for administering and distributing Part A funds through their counties' respective health departments. In San Mateo County, Part A and Part B funds are coordinated through the **San Mateo County Health's Director, Louise Rogers**. Responsibility for Part A fund administration lies with **Matt Geltmaker,** who serves as **Director of the San Mateo County STD/HIV Program** and is responsible for oversight of all Ryan White Part A, Part B, MAI, CDC, HIV prevention, and HOPWA funds as well as subcontractor oversight. In Marin County, Parts A and B funds are administered through **County of Marin Health and Human Services**, whose Director is **Benita McLarin.** She shares responsibility for Part A funds with **Ken Shapiro, Chief Operating Officer.** The **Marin County HIV/AIDS Program** has direct responsibility for Part A fund management and

coordination. Direct oversight of Marin Part A funds is provided by **Nga Le, MPH,** Public Health Program Manager, Communicable Disease & Community Preparedness for the County. An EMA-wide Organizational Chart outlining the above relationships is included in **Attachment 1** of this application.

b) Administration by a Contractor or Fiscal Agent:

N/A - The San Francisco EMA does not utilize a contractor or fiscal agent to administer Ryan White Part A funds.

2. Grant Recipient Accountability:

a) Monitoring:

The San Francisco Department of Public Health is the local government agency responsible for the administration of Part A funds. SFDPH oversees all public health services for the City and County of San Francisco as well as contracts with community providers using processes required by local ordinances. MAI, carry-forward, additional Ryan White funds, and local General funds are placed in separate budget appendices, and have specific and separate invoices. Request for Proposals (RFP) service solicitations delineate fiscal monitoring and reporting expectations for contracted services and all proposals must adequately describe each agency's ability to perform accountability-related activities. This includes the production of specific, measurable goals and objectives; documentation of the agency's prior experience in providing services to target populations; and language capacity. Oversight also includes verification that contractors fully monitor third party reimbursements and document that clients have been screened for and enrolled in all eligible benefits and/or insurance programs so that Ryan White Program funds are only used as the funding source of last resort.

For the 2024-2025 Fiscal Year (3/1/24 - 2/28/25), the San Francisco Department of Public Health is utilizing Ryan White Part A funding to support a total of **42** separate programs. These programs are being operated by **18** different community-based organizations (subrecipients), including local non-profits; the University of California San Francisco; and programs administered by the local county health department. Typically, SFDPH Business Office Contract Compliance staff conducts on-site monitoring visits to **all** of these programs each year along with ongoing programmatic and fiscal monitoring visits. HHS staff attend and participate in all site visits with agencies that receive RWP funding, and all HSS monitoring reports are reviewed and signed by the Director of HHS.

For both the past and current Ryan White Part A fiscal year, there were no major monitoring findings that required corrective actions. In the past, the three most commonly identified items identified in the program and fiscal monitoring process have included: a) guidance for improving client satisfaction survey distribution and returns; b) helping providers appropriately utilize client data to demonstrate compliance with QI related performance objectives; and c) working with providers who may have difficulty in achieving deliverable targets for units of service or clients being served primarily due to challenges in filling staffing vacancies. Often, these issues often stem from new staff at the provider level who require more

detailed training and guidance. The HHS Assistant Director convenes a meeting with the providers and appropriate HHS staff to administer the TA to develop the skills in these and other area of needed improvement. Occasionally, program and client changes over time may require that HHS work with a provider to develop alternative performance objectives, or perhaps lower the threshold of their target goals. Discussions and negotiations on adjusting target goals, units of service, and/or unduplicated clients are very rare, but they do occur, especially when new additional modalities of service are introduced into an existing program.

If other specific programmatic concerns are identified at a Part A-funded agency, information is **immediately** sought from staff of the contracted agency. Contractors may be asked to explain why deliverables are low, why a high staff turnover rate exists, or what actions have been taken to resolve a specific consumer grievance. A recommendation to address the issue is then collaboratively developed, usually accompanied by specific deliverables and target dates for redressing the issue, such as developing a modified work plan within 30 days or completing a process of staff training within 60 days. Providers are required to formally report on their progress in addressing such recommendations in a written action plan to be submitted within an established deadline, as well as during the following year's monitoring process. Grantee staff follow up on areas of concern after reports have been received. TA is provided for contracting agencies in areas such as staff training and orientation, adoption, and replication of best practices, and/or collaboration both By HIH Health Services and Contract Unit's Contract Development and Technical Assistance Unit (CDTA). Agencies with ongoing problems are referred to the Fiscal Compliance Unit's Contract Oversight Committee which works to develop a corrective action plan for the agency to maintain ongoing funding and good standing. As noted above, there are currently no RWPA funded programs involved in a Departmental Corrective Action Plan.

b) Payor of Last Resort:

The San Francisco Department of Health is committed to maximizing third party reimbursement across the EMA to ensure that Part A funds are always used as the funding source of last resort. This is not only to comply with Ryan White Act requirements, but because the fiscal crises local and state systems are facing in the wake of the COVID-19 pandemic compels the region to further maximize its reimbursement streams. To this end, all three SF EMA counties have taken steps to ensure that all available reimbursement sources in the region are fully utilized, including: a) continually educating providers on the availability of third-party reimbursement streams; b) expanding the capacity of local organizations to bill for services, including assistance in obtaining licensure and certification and developing electronic billing systems; c) training agencies to conduct eligibility screening and enrollment for clients, including training to help clients manage their own benefits and eligibility; and d) providing regularly updated information on emerging developments in reimbursements, rates, and requirements. The EMA has also taken steps to verify during the site visits and monitoring process that Part A contractors are fully maximizing reimbursement streams, and that rigorous protocols are followed to ensure that Part A funds are only used **after** all other funding sources have been exhausted. The generalized formula used by HIV service providers to determine client benefits eligibility is to lead each client through an **intake/registration procedure** in

which standardized questions are asked pertaining to factors such as HIV status, residence, age, employment status, income, insurance, health status, and other factors to determine if third party insurance and Medicaid coverage are an option. Providers are also contractually required to assist clients in obtaining all benefits for which they may be eligible, including referring them to agencies that provide benefits assistance. All HIV Requests for Proposals (RFPs) and contracts contain highlighted language stressing that Ryan White funds will be used **only** for services that are not reimbursed through any other source of revenue and new contracting agencies receive training to familiarize them with other appropriate payment sources for specific services and programs.

Service providers are monitored to ensure compliance with Ryan White Program policy and guidelines pertinent to third-party reimbursement. Contracted service providers must provide a description of their screening practices for determining client eligibility for receipt of services, as well as a roster of all third-party payer sources they utilize. Local health department policies in all three EMA counties mandate that if a client is found eligible for coverage from a payer source other than Ryan White - such as Medicaid, Medicare, or private insurance – then that source **must** be billed before seeking reimbursement from Ryan White. **In these cases, payment received is considered as payment in full, and balance-billing to Ryan White is not permitted.** Technical assistance is provided where needed to ensure that agencies modify and improve their eligibility standards or attain greater competency in maximizing third-party billing procedures. HIV Health Services and the SFDPH Office of Contract Development and Technical Assistance also require all agencies funded through Ryan White Programs to provide a complete budget summary of all program funding sources and incomes as well as program expenditures. All programs must demonstrate that their total program funding equals total program expenditures for each fiscal year in the budget.

c) <u>Fiscal Oversight:</u>

The staff of the City and County of San Francisco Controller's Office monitors federal funds awarded to nonprofit organizations. For nonprofit organizations receiving $750,000 or more in federal funds, the Controller's Office reviews audited financial statements and single audit reports for compliance with the Single Audit Act and OMB Circular A-133. In Fiscal Year (FY) 2023, the Controller reviewed single audit reports for a total of **31** SFDPH HIV Health Services-funded organizations including **all 18** Part A-funded community-based organizations. The Controller found that all of these organizations had appropriate and timely processes and practices in place.

San Francisco EMA programmatic monitoring, contract development, oversight, compliance, and monitoring functions are overseen by the Department of Public Health's new **Community Programs Business Office**, created in an effort to consolidate services and maximize efficiencies. The centralized Business Office is staffed by **17** program managers from all SFDPH systems of care and consists of two sections: 1) the **Business Office of Contracts Compliance Unit (BOCC)** and 2) the **Contract Development and Technical Assistance Unit (CDTA).** The Contract Compliance Unit provides annual program review; conducts controller's fiscal and compliance review for SFDPH contracts; performs fiscal audits; oversees provider certification and licensing (PPN and Civil Service); performs site certification reviews; and, if

indicated, oversees corrective action plan development and oversight. The Unit also ensures that contracted Part A programs: a) are effectively managed; b) meet their contract deliverables; c) serve their target populations in professional and culturally competent ways, including adhering to published standards of care; and d) maximize external resources to ensure that Ryan White dollars are always used as the funding source of last resort. Additionally, all EMA member counties employ strategies to clarify provider responsibilities, track contractor performance, monitor service quality, and ensure maximum reimbursements. All BOCC and CDTA staff have been trained by HHS, which maintains regular and ongoing communication to inform them of all HRSA/HAB requirements and updates. HHS staff participate in all site visits with BOCC and review monitoring reports before they are finalized.

Responsibility for fiscal monitoring and oversight of the Ryan White Part A grant lies with a **six-member team** at the San Francisco Department of Public Health Grants, Accounts Payable and Procurement unit. The team is supervised by the **Director of Finance, Jenny Louie,** who supervises and directs staff in the fiscal grants unit and payables section and supervises and directs all fiscal requirements for Federal, State and private grants for the Population Health and Prevention Division (PHP). This includes setting up grant accounting for new grants; reviewing and monitoring grant revenues, expenditures, and positions; analyzing revenues and expenditures; preparing fiscal reports; reconciling grant accounts; and closing out completed grants. Staff of the Office review all Ryan White contractor and subcontractor programmatic budgets and reconcile expenditures in accordance with standard accounting practices. They also approve each grant fund encumbrance in accordance with availability of grant funding.

HIV Health Services maintains a system for tracking all funding by funding source, including formula and supplemental funds. Additional tracking systems are used by SFDPH Contracts Unit and Fiscal Unit staff assigned to work with HHS. A **monthly meeting** attended by staff from all four units ensures accurate tracking across programs. **For FY 2024, all Part A funds were put into contracts; therefore, the EMA had no unobligated dollars.**

HHS contractors submit monthly invoices to the SFDPH Business Office Fiscal Invoice Section for review and submission for reimbursement. The Fiscal Invoice staff has **two** invoice analysts who review invoices for accuracy and performance and - upon approval - forward to the Accounts Payable Contracts and Reconciliation section for payment. The invoice analysts review invoice line items to control for over-invoicing and also ensure that submitted invoices match final or modified contract budget details. The invoice analysts also check the level of contract deliverables (both contract units and unduplicated client targets) quarterly and calculate if the program performance is within the **85%** range required at these “milestone” reviews. Programs not performing within 85% of “milestone” marks have their invoices held without payment while their invoices are sent to the CDTA Program Manager and the HHS Administrator for review and consultation. The program is then contacted, and the source of the underperformance is discussed. If deemed necessary, the program is requested to submit a written explanation and a course of action to correct the issue and work toward getting caught up on contract deliverables. Once approved by the HHS Administrator or Director, the invoice analysts then move forward with processing for payment. Once the AIDS Office Fiscal Analysts review and process for payment, the Accounts Payable – Contracts and Reconciliation section performs their final review and forwards it to the Controller’s Office for payment. Payments are either sent by check via U.S. Mail or deposited electronically into the contractors’ bank account

by SF's Auto Clearinghouse Payment Processing for those contractors who establish this mechanism with the City.

B. Maintenance of Effort

Please see Maintenance of Effort Report in **Attachment 3.**

NEEDS ASSESSMENT

A. Demonstrated Need

1. Epidemiologic Overview

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

According to the US Census, as of July 1, 2023, the total population of the San Francisco EMA is **1,789,748**.[1] This includes a population of **254,407** in Marin County, **808,988** in San Francisco County, and **726,353** in San Mateo County, with widely varying population densities within the three regions. While the density of Marin County is **489** persons per square mile, the density of San Francisco County is **17,323 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 **1,618** persons per square mile is still more than ten times lower than its neighboring county to the north. These differences necessitate varying approaches to providing HIV care within the EMA.

The geographic diversity of the San Francisco EMA mirrors the diversity of the people who call the area home. Nearly three out of every five of the EMA's residents (**59.1%**) are persons of

color, including Asian/Pacific Islanders (**29.8%**), Latinxs[1] (**18.9%**), and African Americans (**4.1%**). In San Francisco, persons of color make up **62.5%** of the total population, with Asian residents alone making up over **one-third** (**37.2%**) of the City's total population. The nation's largest population of Chinese Americans lives in the City of San Francisco and is joined by a diverse group of Asian and South Asian immigrants, including large numbers of Japanese, Vietnamese, Laotian, Cambodian, and Indian residents. A large number of Latinx 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 **42.1%** of residents speak a language other than English at home, with over **100** separate Asian languages and dialects 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.

a. Summary of the Local HIV Epidemic: Please see **HIV Demographic Table** in **Attachment 3.**

HIV Epidemic Narrative: More than 35 years into the HIV epidemic, the three counties of the San Francisco region continue to be severely impacted by HIV – an ongoing crisis that has exacted an enormous human and financial toll on our region. As of December 31, 2023, a total of **14,059** diagnosed persons were living with HIV in the region's three counties, representing **9.9%** of Californians living with HIV and **1.1%** of all persons living with HIV in the US. [2] The SF EMA's region-wide HIV infection rate of **785.5** cases per 100,000 persons means that at least **1 in every 127 residents of the San Francisco EMA is now living with HIV.** At the epicenter of this crisis is the City and County of San Francisco, the region hardest-hit during the initial years of the AIDS epidemic and an area still hugely impacted by HIV**.** SF's 2022 per capita HIV case rate of **1,318.0 per 100,000** is by far the highest in California and is more than **150% higher** than the county with the second highest HIV rate, Los Angeles County, at **514.9** per 100,000.[3]

Reflecting the ethnic diversity of our region, the local HIV caseload is distributed among a wide range of ethnic groups. Because of its initial impact on white men who have sex with men (MSM), whites continue to be the largest single impacted ethnic group in the EMA, comprising **47.6%** of all diagnosed persons with HIV. However, persons of color now make up the majority of persons living with HIV in the EMA, including **27.7%** of cases among Latinx populations; **12.2%** among African Americans; and **8.4%** among Asian / Pacific Islanders. African Americans are significantly over-represented in terms of HIV infection, making up **12.2%** of all persons living with HIV while comprising only **4.1%** of the area's population. This disproportion is even greater among **cis women**, a group in which African Americans make up **31.7%** of all PLWH while comprising only **4.0%** of the region's total cis women population. Among the EMA's hard-hit transgender women population, women of color make up **83.8%** of all trans PLWH, including a population that is **29.2%** African American, **36.8%** Latina, and **11.2%** Asian / Pacific Islander.

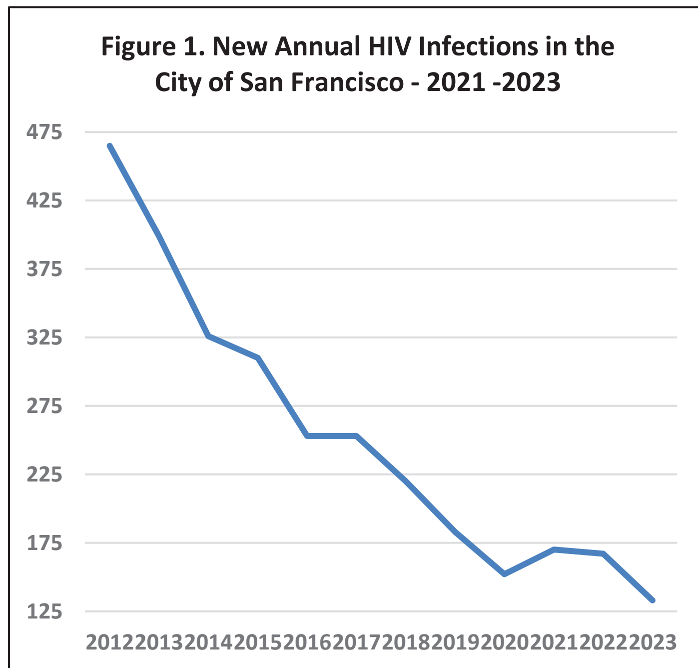
[1] Please note that throughout this application, the commonly accepted term Latinx is used to refer to persons who self-identify as having a Latin heritage. In the San Francisco EMA, however, the current term being used to describe these populations is **Latina/o/e/x**, a term that encompasses the full range of binary and non-binary gender identities within this population.

In terms of transmission categories, MSM continue to make up by far the highest proportion of PLWH in the SF EMA, comprising **81.1%** of persons living with HIV, including MSM who inject drugs. By comparison, only **48.2%** of all PLWH in New York City as the end of 2022 were infected through MSM contact.[4] Other significant transmission categories include heterosexual contact (**7.7%** of PLWH) and heterosexual persons who inject drugs (**5.6%**). **The proportion of heterosexual HIV cases in the San Francisco EMA is believed to be the lowest of any EMA in the US.** Reflecting the high prevalence of HIV among men who have sex with men, the vast majority of persons living with HIV in the San Francisco region (**89.4%**) are cis men, with only **7.0%** of PLWH in the region being cis women, over **74%** of whom are women of color. **The three-county San Francisco region has historically contained what is by far the lowest percentage of women, infants, children, and youth (WICY) living with HIV of any region in the US. Transgender persons** also make up a significant percentage of PLWH, with at least **495** trans individuals living with HIV as of December 31, 2019, representing at least **3.5%** of the region's PLWH caseload.

Finally, the large and growing majority of persons living with HIV in the San Francisco region are age 50 and above, with nearly **two-thirds** of all PLWH in our region being aged 50 and above (**65.5%**), including **695** PLWH aged 75 and older**.** The growing aging population creates significant challenges for the local HIV service system, including the need to coordinate and integrate HIV and geriatric care and to plan for long-term impacts of HIV drug therapies. Meanwhile, persons between the ages of 25 and 44 make up **25.0%** of all PLWH in the region while young adults ages 13 - 24 make up only **0.7%** of all PLWH in the region.

b. Socioeconomic Characteristics of Persons Affected by HIV:

i. Demographic Data: As a result of the SF EMA's integrated and comprehensive collaborative efforts to expand HIV awareness and testing and link and retain persons with HIV in care, new HIV infections in our region continue to decline across all age groups. The total of **255** new cases of HIV infection diagnosed in the SF EMA in calendar year 2023 is the **fewest number of annual new infections in the history of the HIV epidemic,** while the **133** new HIV diagnoses reported in San Francisco County in 2023 represent a dramatic **20% drop** from the **167** diagnoses reported in 2022, following slight increases resulting from the COVID-19 pandemic (see **Figure 1**). Fully **95%** of newly diagnosed persons in 2023 were linked to care **within one month** of diagnosis, while **84%** of people diagnosed during the first nine months of



2023 were virally suppressed within six months. **However, despite the lower numbers of new HIV infections, San Francisco County still has the highest rate of new HIV cases of any county in California, at 24.1 per 100,000 in 2022, as compared to the next highest county, Kern County, at 21.8 per 100,000, and 12.1 per 100,000 for the State of California as a whole.[5]**

In terms of the demographics of new HIV infections, **communities of color** continue to have the highest rates of new HIV infections in the San Francisco EMA. Fully **71.8%** of all new HIV infections in in 2023 involved persons of color, despite these persons comprising **52.4%** of all PLWH in the region. Latinx populations are the most dramatically impacted, making up **43.9%** of new HIV infections as compared to **27.7%** of all living PLWH. Asian / Pacific Islanders are also highly impacted, comprising **14.9%** of new infections in 2023 as compared to **8.4%** of PLWH. Similar increases occurred among **women**, who made up **7.0%** of PLWH at the end of 2019 but **10.6%** of new HIV diagnoses in 2023. Even more dramatic are HIV cases among **transgender persons**, who accounted for **3.5%** of all PLWH at the end of 2023 but **9.4%** of all new HIV cases. Additionally, young people between the ages of 18 and 24 make up only **0.7%** of PLWH in the EMA, but made up **11.8%** of all new HIV diagnoses. By contrast, African Americans made up **12.2%** of new diagnoses in 2023 - a percentage exactly equal to their representation among persons living with HIV. **28.3%** of new HIV infections were among whites, as compared to **47.6%** of all PLWH. At the same time, however, it is important to note that the **overall numbers of new HIV diagnoses** continue to decline significantly in our region, with the disparities above reflecting the early, dramatic impact of HIV largely on gay white male populations.

ii. <u>Socioeconomic Data:</u>

<u>Poverty:</u> It is estimated that at least **58.9%** of all persons living with HIV in the San Francisco region (n=**8,282**) are living at or below 300% of the 2023 Federal Poverty Level (FPL) including persons in impoverished households, while **98.1%** of Part A-funded clients live at or below 400% of poverty.[6] ARIES data also reveals that **76.0%** of active Ryan White Part A clients in the San Francisco region are currently living at or below 138% of FPL while another **14.9%** are living between 139% and 250% of FPL. There are also significant income disparities in SF related to **ethnicity**, with the median household income for whites in San Francisco standing at **$160,007** while the median income for Latinx households is **$84,992** and the median income for African American households is only **$44,142** – about **one-third** of average white household income.

<u>Housing and Homelessness:</u> Because of the high cost of living in the San Francisco Bay Area, persons at 300% of poverty or below have a much more difficult time surviving in our area than those living at these income levels in other parts of the U.S. This is exemplified by the crisis of **housing costs and homelessness** in the San Francisco EMA, issues that have reached crisis proportions and that create formidable challenges for organizations seeking to serve HIV-infected populations. According to the National Low Income Housing Coalition's *Out of Reach 2024* report, Marin, San Francisco, and San Mateo Counties – the three counties that make up the San Francisco region – **are tied with one another as the second, third, and fourth 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 **$64.50 per hour** (see **Figure 2**).[7]

Meanwhile, according to the 2024 HUD Fair Market Rent Documentation System, San Francisco has the **highest HUD-established Fair Market Rental rate in the nation** at **$2,292** for a studio apartment and **$3,359** 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".[8] The combined 2024 Homeless Counts for Marin, San Francisco, and San Mateo Counties identified a combined total of **11,572** homeless persons in the EMA, for an overall rate of **646.7** per 100,000.[9] However, the homeless rate for the City of San Francisco is much higher, at **1,028.8** per 100,000. At the same time, ARIES data for the period March 1, 2023 – February 28, 2024 shows a total of **1,745** total Ryan White clients either in temporary or unstable housing, for a startling homeless rate of **27,406.9** per 100,000 Ryan White patients. Only a little more than **two-thirds** of Ryan White clients in the SF EMA are stably housed (**67.8%**), while **21.3%** live in temporary housing such as shelters and **6.1%** live in unstable housing.

<u>**Burden of HIV in the Service Area:**</u> 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 2023, a total of **11,880** San Franciscans were living with diagnosed HIV, representing **84.5%** of all persons living with HIV in the EMA. **This means that just under 1 in every 70 San Francisco residents is now living with HIV disease - an astonishing concentration of HIV infection in a city with just over 800,000 residents.** The incidence of **1,468.5** persons living with HIV per 100,000 in San Francisco County is **nearly three times** that of Los Angeles County in Southern California, at **514.9** per 100,000.

c. <u>Co-Occurring Conditions:</u> Please see Co-Occurring Conditions Table in **Attachment 5.**

d. <u>Health Care Coverage:</u>

The advent of health care reform through the Affordable Care Act (ACA) has resulted in significant, positive change in regard to the number and proportion of low-income persons with HIV in our region who benefit from affordable and more accessible health insurance coverage. US Census data indicates that only **4.2%** of San Francisco residents were uninsured in 2022, well below the overall national rate of **9.5%** and the California statewide rate of **7.5%.**[10] Nevertheless, significant insurance gaps remain in our region. Analysis of local ARIES data revealed that **30.9%** of all persons enrolled in Ryan White Part A services in the three-county region during the 2023-2024 fiscal year were uninsured at some point during the year, including persons without Medicaid or Medicare, while data provided by the San Francisco Epidemiology Program found that **20.2%** of persons with HIV lacked any form of health insurance at the time of HIV diagnosis.[11] While **74%** of Whites, **81%** of African Americans, and **73%** of Asian / Pacific Islanders had some form of health insurance at the time of HIV diagnosis, only **60.7%** of Latinx persons had insurance, meaning that nearly **2 in every 5** Latinx was uninsured at HIV diagnosis (**39.3%).** MediCal - California's Medicaid program - was the most common public insurance source for most racial/ethnic groups at diagnosis, covering **53%** of African Americans, **35%** of whites and **30%** of Latinx persons.

The most important complementary funding stream to support HIV care for populations with low incomes is the **Medicaid** system, or **Medi-Cal**, as the system is known in California. Medi-Cal is an indispensable link in the chain of support for persons with low-incomes and HIV

in the San Francisco EMA, and it has become an even more fundamental component with the advent of expanded ACA coverage. Medi-Cal fee-for service reimbursements for persons with HIV in the San Francisco EMA total more than **$100 million per year. Medicare** is an additional key insurance stream, providing foundational support for medical and pharmaceutical expenses for persons 65 and older.

California was also one of the very first states to develop a **state-based health insurance exchange** authorized by the ACA, which was conditionally approved to operate by the U.S. Department of Health and Human Services in 2011. The exchange, named **Covered California,** is essentially a **virtual marketplace** that allows individuals who do not have access to affordable employment-based coverage and are not eligible for Medicaid or other public coverage to purchase subsidized health insurance if they earn up to 400% of FPL. Covered California health plans are also available to small employers through the Small Business Health Options Program (SHOP). As of Jan. 31, 2024, a total of **1,784,653** Californians had chosen a health plan through Covered California for 2024, with **306,382** new enrollees and **1,478,271** renewing their coverage. Covered California today provides a critical bridge to affordable care for many persons with HIV in the San Francisco EMA whose incomes do not qualify them for expanded Medicaid coverage.

San Francisco residents have also a longer-standing option of enrolling in the **San Francisco Health Plan,** a licensed community health plan created by the City and County of San Francisco that **now** provides affordable health care coverage to over **145,000** low and moderate-income families. Created in **1994**, the San Francisco Health Plan's mission is to provide high quality medical care to the largest number of low-income San Francisco residents possible, while supporting San Francisco's public and community-minded doctors, clinics, and hospitals. Health Plan members have access to a full spectrum of medical services including preventive care, specialty care, hospitalization, prescription drugs, and family planning services, and members choose from over **2,600** primary care providers and specialists, **9** hospitals and over **200** pharmacies – all in neighborhoods close to where they live and work.

San Francisco also operates **Healthy San Francisco,** a program designed to make health care services available and affordable to uninsured San Francisco residents. Operated by the San Francisco Department of Public Health, Healthy San Francisco is available to all San Francisco residents regardless of immigration status, employment status, or pre-existing medical conditions and as of June 30, 2023 provided health coverage to **18,225** uninsured San Francisco residents.

Finally, the SF EMA relies on reimbursements through the California Office of AIDS **Health Insurance Premium Payment Program (OA-HIPP)**, which pays health insurance premiums for individuals with health insurance who are at risk of losing it and for individuals currently without health insurance who would like to purchase it. As of June 2022, the last date for which statistics are available, a total of **913** OA-HIPP clients were being subsidized for health insurance provided through Covered California while another **1,095** were being subsidized for insurance outside the ACA system.

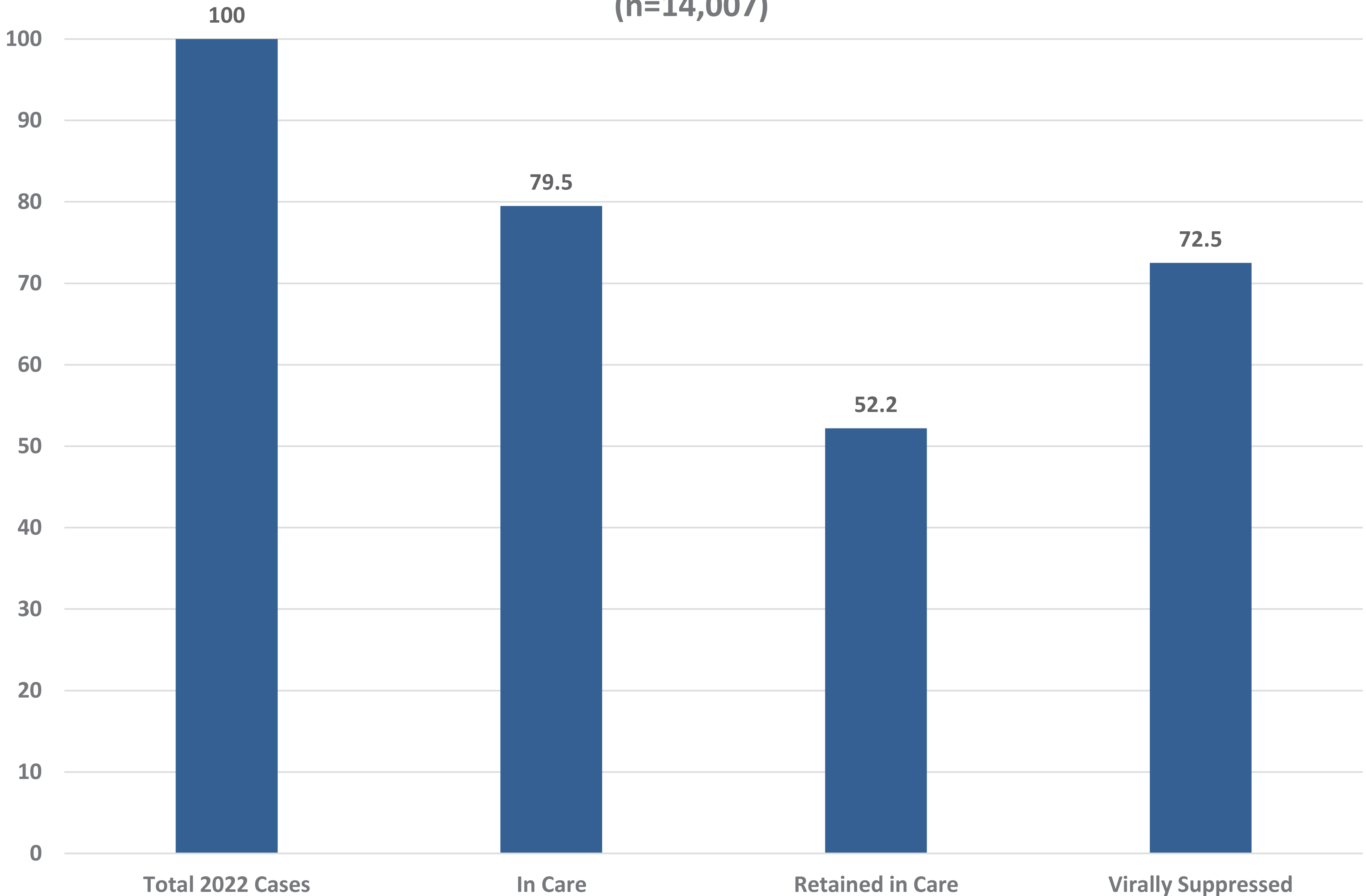
2. **Unmet Need:**

UNMET NEEDS TABLE: EMA – SAN FRANCISCO, SAN MATEO, MARIN COUNTIES

Baseline Reporting Period: January 1 - December 31, 2023

Data Element	Number / Percentage
A. Late Diagnosed: Number of late diagnoses based on first CD4 test performed or documentation of an AIDS-defining condition less than or equal to three months after a new HIV diagnosis.	**44** late diagnoses in calendar year 2023 out of **255** total new HIV diagnoses - **17.3%**
B. Unmet Need: Number / percentage of RWHAP clients with HIV / aware with no CD4 or VL test or outpatient / ambulatory health services visit in the most recent calendar year.	**2,933** clients with HIV / aware with no CD4 or VL test in calendar year 2023 out of **14,059** HIV / aware persons - **20.9%**
C. Not Virally Suppressed: Number / percentage of people with HIV / aware and in care that have a viral load of ≥ 200 copies/mL at most recent test (in 2023).	**1,021** clients with HIV / aware and in care that have a viral load of ≥ 200 copies/mL at most recent test in calendar year out of **11,126** HIV / aware persons in care - **9.2%**

3. HIV Care Continuum: Please see following page. Please note while the In Care metric reflects HIV patients who have had at least **one** documented medical visit in the calendar year, the Retained in Care metric reflects the number of patients with **two or more** documented medical visits during the year, which is not a standard that is adhered to by all medical providers in the EMA. For patients who have been fully virally suppressed for many years and who have no significant co-occurring medical conditions, physicians may require only one office visit per year, despite this being a HRSA metric. The relatively low Retained in Care percentage is similar to the metric for many other regions in the nation.


San Francisco EMA HIV Continuum of Care Among Prevalent Cases, 2022
(n=14,007)
100
79.5
52.2
72.5
0
10
20
30
40
50
60
70
80
90
100
Total 2022 Cases
In Care
Retained in Care
Virally Suppressed

B. Early Identification 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**[12]

1. Planned FY 2025 - FY 2027 EIIHA Activities

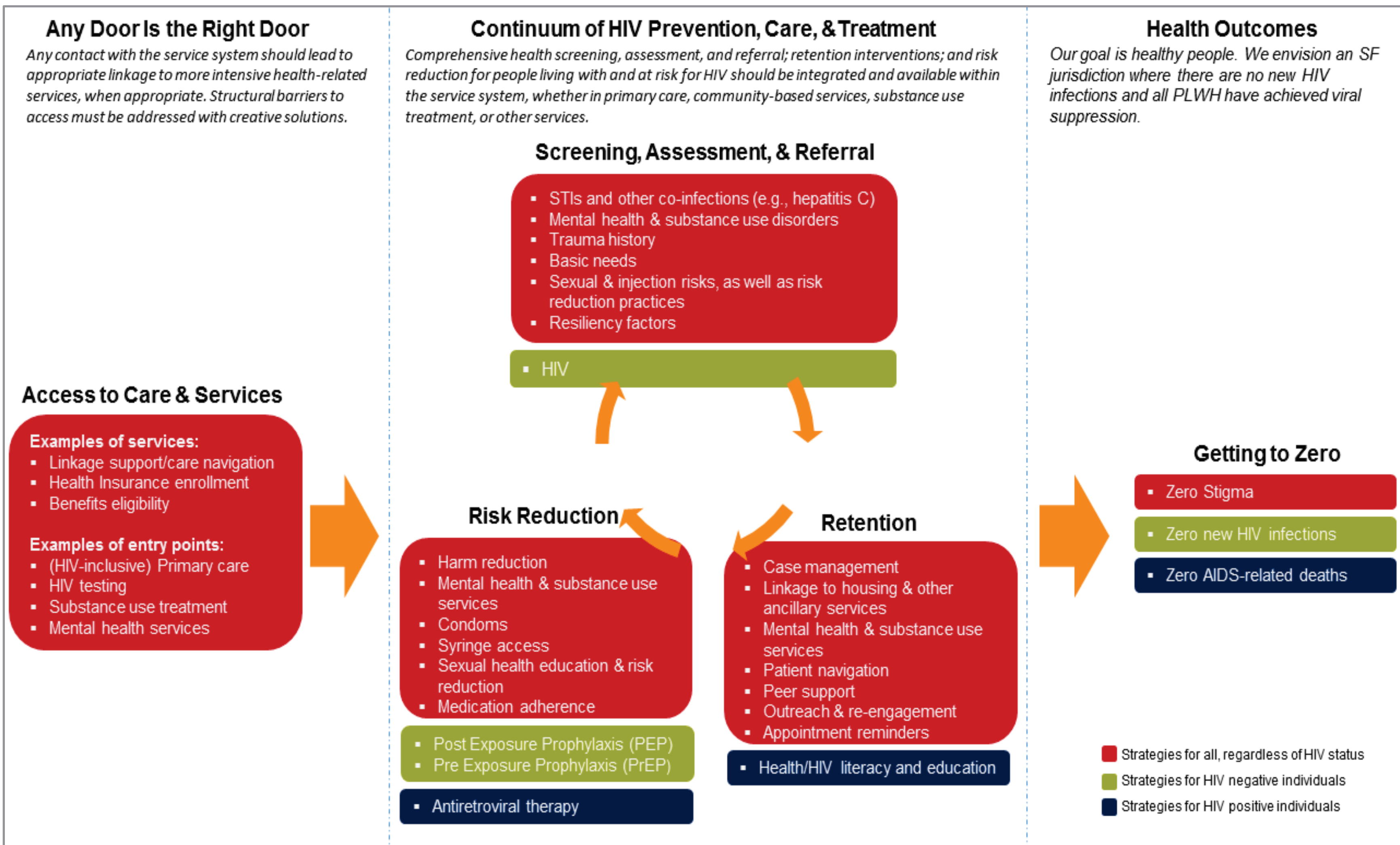
a. Overall EIIHA Strategy:

The SF EMA aims to achieve an HIV prevention and care continuum in which no one is at risk for HIV, and everyone who is living with HIV knows their status, is linked to and retained in care, and is virally suppressed (see **Figure 3**). The EIIHA Plan contributes to improving health outcomes in the following ways:

- Reducing at risk and HIV-infected populations by improving awareness and uptake of PrEP, with a particular focus on African American and Latino MSM, young MSM, and trans women;
- Increasing awareness of HIV status through increasing access to routine HIV testing and community-based rapid testing to detect acute infections. SFDPH continues to promote frequent testing (every 3 to 6 months for the three high prevalence populations - MSM, PWID, and transwomen) and test counselors are trained to deliver this messaging during testing encounters. It is worth noting that the city of San Francisco has the highest rates of HIV status awareness in the nation with only 6.5% not aware of their infection, and with a sero-unaware rate of only 3% among MSM;
- Improving HIV care linkage and retention rates through continued implementation of the LINCS program as well as expanded case management services (see description below);
- Increasing viral suppression as a direct result of improvements along the rest of the continuum; and
- Continuing to conduct Data to Care (DTC) activities as a joint initiative between HIV surveillance and the LINCS program, with a special focus on African American and Latino MSM and trans women.

Additionally, the San Francisco Department of Public Health (SFDPH) conducts a **medical chart review** of **every** person living with HIV in San Francisco **every 12 months** to document and update variables not collected at time of initial diagnosis, including vital status, use of additional therapeutic and prophylactic treatments, subsequent opportunistic illnesses, most recent address, and additional CD4 and viral load results. This process also allows us to track and maintain a **current address for all PLWH**, which is a key component to the success of the DTC and LINCS programs. Address information is **geocoded to the census tract level,** enabling HIV surveillance to produce maps shared in our annual epidemiology report and to our

Figure 3: San Francisco Jurisdiction Holistic Health Framework for HIV Prevention and Care



prevention partners that show, for example, the geographic distribution of all PLWH, newly diagnosed cases and their viral suppression and linkage to care rates, as well as testing rates by age and zip code.

a. Primary Activities To Be Undertaken:

The 3-year FY 2025 - FY 2027 EIIHA Plan (March 1, 2025 - February 28, 2028) will encompass **three** broad, high-impact prevention (HIP) activity areas that mirror those of preceding EIIHA plans and that build on the significant progress the SF EMA has made through its **Getting to Zero (GTZ)** initiative. The **first** area involves **identifying individuals who are unaware of their HIV status.** The EMA will continue to maintain: a) equity-focused, high-volume, community-based **targeted HIV testing** for MSM, persons who inject/use drugs (PWID/UD), youth and young adults, and transgender women, particularly persons experiencing homelessness. Strategies incorporate the latest testing technologies as appropriate, including: a) high-quality rapid testing, acute RNA pooled screening, and rapid 4th generation combination antibody / antigen (Ab/Ag) tests at sites that do not have access to pooled RNA testing; b) integrated HIV/STI/Hep C testing, incorporating hepatitis B and tuberculosis testing wherever feasible and appropriate; c) routine testing of partners of HIV-positive individuals; d) routine opt-out screening in clinical settings; e) routine perinatal screening; and f) accessible, high quality laboratory-based HIV testing and case reporting. At the same time, over the next three years, the SF EMA will cast a wider net to: a) address disparities in new infections among Black/African Americans and Latino/a/x/e communities and b) find cases in low incidence populations such as cis-gender women. These efforts will include: a) implementing culturally specific community engagement and mobilization; b) further normalizing and de-stigmatizing HIV and STI testing to reach beyond those who traditionally test by continuing to expand medically based HIV opt-out testing with 3rd party reimbursement; c) exploring opportunities to expand integrated approaches to sexual health services in novel settings such as HIV/STI screening and PrEP delivery at pharmacies; and d) focusing on mobile services and tele-health in response to the COVID-19 pandemic.

The **second** key activity area involves ensuring that HIV-positive individuals are successfully linked to essential medical and social services based on individual needs. Specific activities will continue to be tailored to meet the needs of its identified focus population groups, with a particular emphasis on continuing to implement the city-wide **Linkage Integration Navigation Comprehensive Services (LINCS)** program. Created in 2015, LINCS is a comprehensive, national model HIV and STI partner services and linkage to care program. In terms of HIV services, LINCS offers: 1) partner services to individuals newly diagnosed with HIV; 2) linkage to care for individuals newly diagnosed with HIV; and 3) navigation for individuals living with HIV who are not in care. LINCS is a highly effective program that aims to increase the number of individuals living with HIV who are effectively linked to and anchored in care. LINCS aims to offer partner services **within 14 days** and link all SF residents testing positive for HIV to care and treatment **within 30 days**. LINCS also aims to increase linkage to care and viral suppression among individuals enrolled in LINCS Navigation. For SF residents newly diagnosed with HIV, LINCS pairs anyone newly diagnosed with a LINCS team member to build a supportive relationship and offer tailored, individualized services and support for **up to three months**

PREVIEW Date: Oct 01, 2024 Workspace ID: WS01394483 Funding Opportunity Number: HRSA-25-054

following diagnosis. This can include partner services; linkage to care; navigation support including referral to social services (housing, food, transportation, benefits, etc.); appointment reminders; counseling and education; and accompanying patients to appointments, among other services. LINCS also receives referrals from HIV providers and uses Data to Care (D2C) lists to help identity individuals who are out of care and could benefit from linkage and/or navigation. The LINCS program supports **16** highly trained, front-line disease intervention staff. LINCS uses a **cross-training model and staff** within the LINCS program through which staff members are comprehensively trained to provide partner services for HIV and other STIs, including syphilis and mpox, and HIV navigation services.

The **third** key activity aims to **promote and facilitate ever-widening utilization of pre-exposure prophylaxis (PrEP) throughout the EMA**, and in particular, to address **disparities in PrEP uptake** in relation to under-utilizing populations such as Black/African Americans, Latino/a/x/e populations, and transgender women. DPH is leveraging multiple funding sources to implement a multi-pronged approach that includes: 1) community, clinic, and pharmacy-based PrEP programs; 2) training of HIV test counselors to provide a gateway to PrEP; 3) social marketing; 4) mobile PrEP; 5) expanded access to long-acting injectable PrEP; and 6) public health detailing. San Francisco has vigorously embraced PrEP as an effective approach to reducing new infections among high-risk individuals in the EMA, and has become known as the premier hub of PrEP use worldwide, with San Francisco chosen as **one of two** 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, which has since evolved into an ongoing program.[13] Key elements of San Francisco's PrEP strategy include the following:

- Reducing the interval from the time when a person wants to begin PrEP to receiving their first PrEP dose by increasing access to same-day PrEP;
- Facilitating connections between PrEP programs to ensure no one is on a waiting list;
- Utilizing California's PrEP Drug Assistance Program (PrEP DAP);
- Increasing collaboration with the SF School District, its CDC Division of Adolescent and School Health (DASH)-funded program, and local colleges and universities to open additional access points for young MSM and trans female students;
- Incorporating PEP and DoxyPEP into all PrEP discussions, so that clients who choose not to start PrEP know how to access PEP;
- Closely monitoring PrEP access for young MSM, trans women, and PWID, who have particular challenges related to insurance and stability, and make adjustments in our strategies as needed;
- Continuing to learn from communities about their unique barriers and support and work with community members to develop and disseminate culturally appropriate messaging to address misinformation and remove roadblocks to PrEP access;
- Strengthening panel management systems for PrEP programs at City Clinic, San Francisco Health Network sites, and local community-based organizations to identify patients on PrEP who are lost to follow-up or have discontinued PrEP due to changes in insurance status, so there is no interruption in PrEP;
- Scaling up a pharmacist-delivered PrEP program at a community-based pharmacy in the Mission district serving Latino clients;

- Ensuring that PrEP services and materials are available in Spanish;
- Integrating PrEP education for PLWH into Ryan White services and other services for PLWH, including PrEP referrals for their partners;
- Expanding access through incentivized, mobile PrEP and through the PrEP program at SF City Clinic, our municipal STD Clinic; and
- Expanding harm reduction services at housing sites.

Additionally, in summer of 2023, the Community Health Equity and Promotion (CHEP) branch collaborated with **17** community partners to open **seven groundbreaking new Health Access Points (HAPs)**. These HAPs are **equity-focused, one-stop shops** that support sexual health and wellness in welcoming and stigma-free environments. The HAPs are designed to reduce disparities by making whole-person care more accessible to San Francisco's diverse communities through an integrated and holistic model that includes clinics, mobile clinics, and health centers operated by community-based organizations. The goal of the Health Access Point system is to ensure all San Franciscans can easily obtain high quality Hepatitis C (HCV), HIV, and sexually transmitted infections (STIs) prevention and care services, overdose prevention, and access to primary care and mental health services. While everyone is welcome, each HAP site is tailored to meet the unique needs of **one priority population.** The HAPs specifically focus on: a) the Black / African American community; b) the Latina/o/e/x community; c) the Asian American / Native Hawaiian / Pacific Islander community; d) trans women; e) transition age youth (TAY); f) gay / bisexual men and other men who have sex with men; and g) people experiencing homelessness and/or people who use drugs.

b. <u>Anticipated Outcomes of the Regional EIIHA Strategy:</u>

The FY 2021 San Francisco EMA EIIHA Plan has **three** primary goals: **1)** to increase the percentage of individuals in Marin, San Francisco, and San Mateo counties who are aware of their HIV status; **2)** to increase the percent of HIV-positive individuals in our region who are effectively engaged in HIV care; and **3)** to reduce disparities in PrEP uptake, HIV infection, HIV testing, and successful and sustained linkage to care. SF EMA's EIIHA plan also includes approaches designed to reach the specific communities and individuals who are most vulnerable to HIV infection **before** they become infected. If GTZ is successful, the need for an early intervention plan should greatly diminish, because new infections will be virtually eliminated.

The local EIIHA Plan directly incorporates the four key pillars, or strategies, highlighted in both the updated 10-year national HIV strategy entitled *Ending the HIV Epidemic: A Plan for America*, published in February 2020, and in the new Ryan White-funded *Ending the HIV Epidemic* funding opportunity recently published by HRSA. These pillars consist of the following:

- **Pillar One: Diagnose** all people with HIV as early as possible;
- **Pillar Two: Treat** people with HIV rapidly and effectively to reach sustained viral suppression;

- **Pillar Three: Prevent** new HIV transmission by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs); and
- **Pillar Four: Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Specific outcomes of the SF EMA EIIHA strategy are also codified as key **objectives** in both the updated 10-year strategy and the new Ending the HIV Epidemic funding opportunity. These include: a) reducing the number of new HIV infections in the US by 75 percent within the next five years; and b) reducing the number of new HIV infections in the US by 90 percent within 10 years, for an estimated total of 250,000 HIV infections averted over that time.

The FY 2021 San Francisco EIIHA plan will reach many individuals who are disconnected from the system in order to bring them into HIV prevention, testing, linkage, and care services. Routine HIV testing, targeted community outreach, expanded case management services, and PrEP services specific to underserved communities will help to reduce disparities among groups such as MSM of color, substance users, African American women, uninsured and economically impoverished populations, homeless persons, and young MSM – all populations that have experienced historical HIV access and treatment disparities along with high rates of late HIV testing. The San Francisco EMA will utilize its EIIHA plan and matrix to focus on increasing awareness of HIV status and promoting treatment utilization among underserved populations as a way to continue to address HIV-related health disparities.

b. Primary Collaborations:

HIV Health Services, which is housed in the Ambulatory Care Branch of the San Francisco Health Division, works in close partnership with the three branches in the Population Health Division: 1) the Community Health Equity & Promotion (CHEP) Branch; 2) the Disease Prevention & Control (DPC) Branch; and 3) the Applied Research, Community Health Epidemiology & Surveillance (ARCHES) Branch. All of these units plan services, design interventions, and share data and emerging findings. CHEP oversees community-based prevention and testing services, with DPC overseeing the LINCS program and operating City Clinic (the municipal STD clinic which offers HIV testing, PrEP, and HIV early care); and ARCHES maintaining the SF spectrum of engagement data as well as facilitating data to care and data to PrEP strategies. In addition, the DPH Primary Care Division is a close partner, providing routine HIV testing, care for people living with HIV, and PrEP access and navigation services. Through a strong working relationship, these three partner entities 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 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 EIIHA Plan is supported by two additional key collaborators – 1) the **HIV Community Planning Council (HCPC),** our region's merged HIV prevention and care community planning group, which includes HIV prevention and care service providers from all three counties as well as prevention and care consumers, and 2) the **Getting to Zero (GTZ) Consortium**, a multi-sector

independent consortium of public and private sector agencies, service providers, consumers, and planners operating under the principles **of collective impact**. Modeled after the UNAIDS initiative, the consortium aims to achieve zero new infections, zero HIV-related deaths, and zero stigma. This "getting to zero" vision has become the guiding framework for SF City as a whole. In this spirit, the HCPC and the GTZ coalition work with DPH to establish and implement priorities to improve outcomes along the HIV prevention, care, and treatment continuum.

To address syndemics and overlapping vulnerabilities, SF has also developed several iterations of the **San Francisco Integrated Ending the Epidemics Plan**, including the most recent 2024-2026 version which was finalized as this application was being prepared. **The new version of the Plan provides a broadly integrated vision for improving overall health in San Francisco that incorporates not only HIV, but the parallel and related epidemics of Hepatitis C (HCV) and sexually transmitted infections (STIs).** The plan proposes the **integration of HIV, HCV, and STI prevention, care and treatment services**, as well as the application of a **whole person care approach** which acknowledges the need to consider the full range of client issues when preparing effective approaches (see text box above). The new plan incorporates a series of detailed action steps, milestones, and deliverables that address the need to: a) achieve racial equity; b) incorporate a housing first strategy; c) address mental health and substance use prevention and treatment needs, including the need for harm reduction services; d) achieve economic justice; and e) reduce stigma in regard to both infection diseases and the behaviors and factors that lead to their transmission. Key collaborating groups involved in developing this new integrated plan included the following:

Summary of Integrated Services and Whole-Person Care Approach from SF 2024-2026 Integrated Ending the Epidemics Plan

Given the overlap in the populations experiencing persistent disparities in SF, whenever appropriate, all three epidemics are approached jointly to ensure a whole-person care approach to HIV, HCV, and STI prevention, care, and treatment. This aligns with key values and principles in the SF EtE Plan.

1) **Integration of HIV, HCV, and STI prevention, care and treatment services, and harm reduction and overdose prevention:** Given the interconnectedness of these diseases and the broader drivers of the disparities such as substance use, mental health disorders, homelessness, poverty, racism, homophobia, sexism, and transphobia, to succeed at ending the epidemics, SF has committed to fully integrated systems and programs whenever appropriate that are person, not disease-centered.

2) **Whole person care:** In the broadest sense, whole person care is predicated on the understanding that the best way to care for people with complex needs is to consider the full range of those needs – including physical, mental, social, and economic needs. SF's whole person care approach builds on an "ecosystem

PREVIEW Date: Oct 01, 2024 Workspace ID: WS01394483 Funding Opportunity Number: HRSA-25-054

- Ending the Epidemics (ETE) Steering Committee
- SF Department of Public Health ETE Leadership Committee
- SF Department of Public Health HIV Working Group
- SF HIV Community Planning Council (HCPC) & Affairs Committee
- Getting to Zero SF Steering Committee
- SF HIV/AIDS Providers Network
- SF HIV Housing Workgroup
- End Hep C SF leadership
- Frontline Organizing Group (SF FOG)

San Francisco HIV planners and providers also collaborate closely with the new **Overdose Prevention and Harm Reduction Education in Shelters and Housing Initiative (OPHRESH)** -a two-year program designed to provide training, technical assistance, and support to all funded health service providers in SF in order to integrate reduction and overdose prevention (ODP) policies and practices into their agencies' overall service approaches and to enhance learning and engagement to collectively reduce overdose deaths in housing facilities in and through the Homelessness Response System (HRS). The OPHRESH program is designed to: 1) improve and advance learning and engagement in harm reduction and overdose prevention to reduce overdose deaths in San Francisco's Homeless Response System (HRS); 2) build the internal capacity of agencies through engagement, workshops, and technical assistance; and 3) support successful implementation of HSH's Overdose Prevention (ODP) Policy throughout all agencies. Key collaborators in the OPHRESH program include the National Harm Reduction Coalition (NHRC), the Drug Overdose Prevention and Education (DOPE) Project, and the San Francisco Department of Homelessness and Supportive Housing (HSH).

Additionally, although not required by HRSA, in San Francisco, the HCPC 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 B, C, D, and the EHE program play an active role on the Planning Council to ensure integration and coordination of EIIHA activities with other Ryan White-funded services.

3. Description of Target Populations

a. Selected Target Populations:

To define and focus EIIHA activities, the following **three** populations will serve as the key target groups for the FY 2025 San Francisco EMA EIIHA Plan:

1. Latinx Populations
2. Persons Experiencing Homelessness (PED)
3. Justice Involved Populations

The target populations have been selected on the basis of several key factors. From an epidemiological standpoint, these three populations together encompass **more than half** of all persons currently living with HIV in the San Francisco EMA. The populations also represent groups that are highly prioritized in the EMA's current Ending the Epidemics Plan, a product of intense study and collaborative planning. Most significantly, the selected populations represent the groups **most likely to experience barriers in accessing and remaining in care and attaining viral suppression,** and are the populations that our EMA must most urgently address in order to continue to work toward our goal of zero new infections within the next decade.

Figure 3. Profile of Latinx HIV Incidence and Prevalence in the San Francisco EMA – CY 2023

Group / Exposure Category	New Diagnosed HIV Cases 1/1/23 - 12/31/23		Persons Living with HIV as of 12/31/23	
	Number	%	Number	%
Total	**112**	**100%**	**3,889**	**100%**
Current Gender				
Female	11	9.8%	287	7.4%
Male	95	84.8%	3,408	87.6%
Transgender / Other Gender Identification	6	5.4%	194	5.0%
Age Group at Diagnosis or End of Year				
0 - 12	0	0.0%	1	0.0%
13 - 17	0	0.0%	1	0.0%
18 - 24	15	13.4%	55	1.4%
25 - 44	81	72.3%	1,475	37.9%
45 - 49	7	6.3%	440	11.3%
50 - 59	6	5.4%	1,032	26.5%
60 - 64	2	1.8%	401	10.3%
65 and Over	1	0.9%	484	12.4%
Transmission Category				
Male-to-male sexual contact (MSM)	81	72.3%	2,721	70.0%
Injection drug use (IDU)	3	2.7%	151	3.9%
MSM and IDU	2	1.8%	330	8.5%
Heterosexual contact (includes presumed heterosexual contact)	17	15.2%	416	10.7%
Mother with or at Risk for HIV (Pediatric)	0	0.0%	13	0.3%
Transgender Sexual Contact	5	4.5%	188	4.8%
Unknown risk	4	3.6%	63	1.6%
Other	0	0.0%	7	0.2%
TOTAL	**112**	**100%**	**3,889**	**100%**

Latinx Populations: Latinx populations make up what is by far the fastest growing subpopulation of persons living with HIV in the San Francisco EMA. As of December 31, 2023, Latinx persons made up **27.7%** of all persons living with diagnosed HIV in the region, the second largest ethnic group

PREVIEW Date: Oct 01, 2024 Workspace ID: WS01394483 Funding Opportunity Number: HRSA-25-054

after whites. At the same time, however, in calendar year 2023, Latinx populations made up **43.9%** of all new HIV infections – by far the most heavily impacted ethnic group in the EMA. In fact, Latinx persons have had both the largest number and the highest percentage of new HIV cases since 2018. As shown in **Figure 3** above, a total of **3,889** Latinx persons were living with HIV in the EMA at the end of 2023. This highly diverse population includes a significantly higher percentage of **transgender** persons versus the HIV population as a whole (**5.0%** vs. **3.5%**); a higher percentage of HIV cases resulting from **heterosexual contact** (**10.7%** vs. **7.7%**); a higher percentage of HIV cases through **transgender sexual contact** (**4.8%** vs. **3.4%**); and a significantly higher proportion of **younger people** living with HIV, with **half** of Latinx persons living with HIV being age 49 and below (**50.6%**) as compared to only **34.5%** of the overall EMA HIV population. Additionally, a striking **13.4%** of all new Latinx infections in 2023 were among persons ages 18 to 24, as compared to only **.7%** of overall new HIV infections in our region. According to the California Health Care Foundation, Latinx populations have by far the lowest rates of insurance enrollment of any ethnic group in California, with **11.4%** of Latinx persons being uninsured in 2022 versus **7.4%** for the state as a whole.[14] While HIV continuum indicators for Latinx populations who are engaged in care are relatively high, a disproportionate number of Latinx persons continue to become infected with HIV despite increased efforts to reach and serve these populations. Key barriers to more effective Latinx HIV prevention efforts include language barriers, particularly in regard to the high number of recent Latinx immigrants to the EMA; a shortage of skilled and proficient Spanish-speaking professionals to provide medical and psychosocial services to this populations; a lack of diverse staff capable of addressing the needs of Latinx persons who come from a broad range of Caribbean, Latin American, and South American cultures; and continuing stigma reported by Latinx provider agencies, including stigma related to HIV disease, the behaviors that transmit HIV, and traditional medical services.

Persons Experiencing Homelessness: As noted above, nearly **one-third** of Ryan White clients in the SF EMA were either homeless or unstably housed during the most recent 2023-2024 Ryan White fiscal year, with **21.3%** live in temporary housing such as shelters or on the streets and **6.1%** live in unstable housing. Homelessness and unstable housing create severe barriers to accessing HIV care, maintaining consistent medical treatment, and remaining adherent to HIV medications. Prior research has repeatedly shown that homelessness is associated with a range of chronic health problems, including substance abuse and mental illness, physical and sexual violence, and infectious diseases such as tuberculosis and HIV. Homeless persons also must often prioritize meeting basic life needs such as food and shelter over obtaining consistent medical care, and often have difficulty traveling to medical appointments or obtaining regular HIV testing. Homeless persons also suffer from higher rates of mental illness, substance use disorders, and other conditions which can serve as barriers to accessing and remaining in HIV care. Fully **51%** of persons reached through the 2024 San Francisco Homeless Count, for example, stated that they had a disabling psychiatric or emotional condition such as schizophrenia or depression, while **52%** stated that they frequently abused alcohol or drugs, including prescription drugs not prescribed for them. All of these factors contribute to the fact that homeless persons in the SF EMA have by far the **lowest** rates of viral suppression of any group in the region at an alarming **34%,** as compared to rates of **74%** for the EMA as a whole and **76%** for non-homeless persons.[15] In San Francisco,

housing status is in fact the **strongest predictor** of viral suppression – persons who are housed are more than **twice as likely** to be virally suppressed than those who are unhoused.

Justice Involved Populations: Persons with current or past experience with the criminal justice system and incarceration are a severely impacted but less visible population that experiences significant barriers to retention in HIV care and adherence to HIV medication regimens, particularly in regard to high rates of mental health and substance use disorders and frequent treatment interruptions due to moving in and out of incarceration settings. According to data supplied by the HIV Integrated Services Center of Excellence – a Center specifically focused on the coordination of care for HIV-positive incarcerated and post-release persons in San Francisco County's **five** jails – a total of **278** persons living with HIV were incarcerated in in 2022. **10%** of these persons were gender non-conforming; **32%** had severe mental illness; **45%** had a stimulant use disorder; and **22%** had an opioid use disorder. **Only 53% of this population had a documented visit with an HIV primary care provider in SF in the year prior to incarceration while only 39% had documented viral suppression in the past year.**

b. Strategies to be Utilized with the Target Populations:

The San Francisco EMA will continue to 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 both the three prioritized target populations above and for all persons who are currently unaware of their HIV status or who are aware of their HIV status but are inconsistently retained on care and treatment. These activities are closely coordinated with activities conducted by the HIV prevention units in the three EMA counties. Efforts to better reach and serve the target populations are also highly prioritized within the EMA's **Ending the HIV Epidemic (EHE)** program, which prioritizes a number of initiatives specifically related to these groups.

In terms of Latinx populations, the San Francisco EMA utilizes Part A MAI funds **exclusively** to support services for low-income HIV-infected Latinx populations through the **Mission Center of Excellence** that has been established in the heavily Latinx Mission district by **Mission Neighborhood Health Center.** The Center provides culturally competent, integrated, bilingual/bi-cultural medical and health services to community members living with HIV, with an emphasis on Spanish-speaking Latinx clients. In addition to providing direct medical/ambulatory health services through a staff of five bilingual/bicultural professionals, MAI funding helps support the cost of medical case management, mental health counseling, and substance abuse 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.

At San Francisco General Hospital, a medical program was introduced in early 2019 called **POP-UP (Positive-health Onsite Program for Unstably-housed Populations),** designed to provide flexible, comprehensive, and patient-centered care specifically designed to reduce health disparities among **homeless and unstably housed individuals living with HIV in San Francisco**. The POP-UP clinic sees HIV patients who are homeless or unstably housed who are not virally suppressed, and who come to the clinic for urgent care or health care needs of a **non-appointment, drop-in basis.** The program builds on our growing awareness that many patients with HIV who are unstably housed often do not keep regularly scheduled medical

appointments, but often **do** visit the Zuckerberg San Francisco General Hospital Urgent Care Clinic when their own time permits. The POP-UP Clinic team consists of physicians, nurses, and a social worker who actively work together to provide care and coordination for this population. To create a low barrier to access care, POP-UP is open five days a week, on afternoons from Monday to Friday. No appointments are necessary and patients in this program may visit the clinic at any time without advance notice and receive care. POP-UP provides incentives for linkage and retention in care, enhanced patient outreach, and referral for emergency and permanent HIV housing.

EHE funds also provide support for the **HIV Homeless Outreach Mobile Engagement (HHOME)** program operated by the San Francisco Community Health Cener, an HIV care engagement initiative focused on HIV-positive homeless and unstably housed people. HHOME works to address the severe health disparities for HIV+ people experiencing housing instability/homelessness in San Francisco, who as noted above have significantly lower levels of care engagement, retention, and viral load suppression than the community as a whole. San Francisco Department of Public Health's **Whole Person Integrated Care (WPIC) Street Medicine team** provides transitional outpatient medical care and medical case management and to clients with HIV who are experiencing homelessness, in a flexible, drop-in model as well as street-based medical outreach and care. As noted above, San Francisco's **LINCS** program supports enhanced linkage to and retention in care for all PLWH who face significant barriers to HIV care access and adherence, with EHE funds supporting intensive one-on-one support to anchor these individuals in care, and to support their ongoing care retention and treatment adherence for at least 3 months following initial care engagement or re-engagement. The SF Department of Public Health has also utilized EHE funded to implement **LAI (Long-Acting Injectable) ART clinics** with a focus on prioritizing homeless and unstably housed PLWH.

Meanwhile, in regard to persons with criminal justice involvement, the HIV Integrated Services Center of Excellence **Clinical Care and Re-Entry Services Program (C-CARES)** utilizes post-release navigation services and multidisciplinary low-barrier clinic model have to improve care outcomes for PWH leaving jail. Since its initiation in July 2022, the C-CARES program has bridged **79** persons with HIV from jail to post-release medical care with the support of EHE-funded navigation services. Through this program, **73%** of patients have sustained engagement in HIV care and **82%** remain virologically suppressed at the time of this writing. Efforts to improve outcomes and expand the scale and impact of this program are expected to be included in the EMA's new EHE application being submitted in October 2024. EHE services are also utilized to support San Francisco Jail Health Services in providing **comprehensive medical care and medical case management** for clients currently or recently incarcerated in the San Francisco County Jail system.

- **APPROACH**

A. Planning Responsibilities

1. <u>Letter of Assurance from Planning Council:</u> Please see letter in **Attachment 7**.

2. <u>Resource Inventory:</u> Please see Coordination of Services Table in **Attachment 8.**

- **WORK PLAN**

A. HIV Continuum Table and Narrative

1. HIV Care Continuum Table: Please see table in **Attachment 9.**

2. HIV Care Continuum Narrative:

a. How the Care Continuum is Utilized in Planning and Prioritization:

The ongoing movement toward a **syndemic approach** to the HIV epidemic is based on our growing understanding of the interrelatedness of the issues that underlie ongoing HIV infection and care engagement and retention, and of our need to address these issues using a **multi-faceted, integrated approach**. The San Francisco EMA is pleased to have partnered with the California Department of Public Health in the development of the state's current **Ending the Epidemics Integrated Statewide Strategic Plan 2022-2026 –** a comprehensive plan that for the first time **simultaneously addresses the interwoven issues of HIV, HCV, and STI infection in California** through a lens that recognizes and acknowledges that critical social and environmental factors can limit people's choices and influence their access to information and care.[16] The Plan acknowledges that to truly end the HIV epidemic, it is necessary to provide both basic health services such as vaccinations, testing, and treatment while **at the same time** working to give people and communities the resources they need to stay healthy and access health care. For these reasons, the State's Integrated Plan is organized around **six** key social determinants of health: **1) racial equity; 2) housing; 3) access to healthcare; 4) mental health and substance use services; 5) economic justice; and 6) stigma.** These same pillars are utilized and applied in San Francisco's own newly developed **Integrated Ending the Epidemics Plan 2024-2026,** a document that recognizes that despite progress in reducing HIV incidence and increasing HIV retention and viral suppression rates, "the most challenging work remains, because it requires going beyond the simple provision of services to addressing the deeply complex issues of poverty, racism, homophobia and transphobia, access to care, mental health and substance use, incarceration, and much more."[17]

Services provided in the San Francisco EMA using Ryan White Part A funds for the period March 1, 2025 through February 28, 2028 will reflect the priorities of the 2024-2026 Integrated Ending the Epidemics Plan while recognizing that Part A services are carefully defined and proscribed, providing "backbone" support for basic HIV linkage and care services in our region for persons who have no other payment option available. As with the EMA's 2025-2028 EIIHA Plan, Part A funding will most specifically address **Pillars Two and Four** of the national Ending the HIV Epidemic Plan, specifically focusing on **treating** people with HIV rapidly and effectively to reach sustained viral suppression and **responding** to potential HIV outbreaks to get needed prevention and treatment services to people who need them. In regard to **treatment,** SF is home to one of the first outpatient HIV clinics in the nation (**Ward 86** at Zuckerberg San Francisco General Hospital); was the first city to establish a policy that anti-retroviral therapy (ART) should be **universally offered** to people upon HIV diagnosis; and is widely known for its rapid adoption of new advances in treatment. For example, **PHAST (Positive Health Access to**

Services and Treatment) is an interdisciplinary team at Ward 86 staffed by a registered nurse, a clinician, and a social worker who offer low-barrier access to RAPID ART and linkage to care support to patients visiting Ward 86 after a new HIV diagnosis or re-engaging in care after being out of care. The PHAST team supports over **500 patients a year**, primarily members of our priority populations described above, by providing expedited clinic intake, nursing care coordination, and psychosocial stabilization to patients vulnerable to being lost to follow-up due to high rates of homelessness, incarceration, mental illness, and active substance use. The PHAST model addresses the social determinants of patient health along with addressing the barriers to care.

SF also has exceptional capacity for providing state-of-the-art HIV treatment, including through our **six** Ryan White-funded **HIV Centers of Excellence (CoEs).** San Francisco's CoEs were created to serve severe-need clients and members of disadvantaged and disproportionately impacted populations through the placement of primary medical care at the **center of an integrated service delivery model** providing coordinated access to both primary medical care and critical services. Each Center of Excellence must provide: **1)** primary medical care; **2)** medical case management; **3)** psychiatric assessment and psychiatric medication monitoring; **4)** treatment adherence and medication assistance; **5)** outpatient mental health treatment; and **6)** substance use assessment, counseling, and referral. Each multidisciplinary CoE, while open to all, is customized to serve a particular population that has unique or disproportionate barriers to care, needs additional or unique services, or requires a special level of expertise to maintain them in care, as follows:

- **Homeless Aging and Long-term Survivors (HALT) Center of Excellence:** Focuses on services for people experiencing housing instability and homelessness; men who have sex with men; Latina, African American and trans women; and immigrants, with a focus on undocumented Spanish-speaking persons.
- **HIV Integrated Services (HIV-IS):** Focuses on the coordination of care for HIV-positive incarcerated and post-release people and serves the SF County jails.
- **Mission Center of Excellence:** Focuses on services for Latino/Latina populations, including monolingual Spanish speakers and immigrants, regardless of legal status.
- **Black Health Center of Excellence:** Focuses on services for underserved and uninsured Black/African Americans, including cis women and trans women.
- **Tenderloin Area Center of Excellence:** Focuses on homeless and marginally housed persons, active substance users; transgender persons, Asian/Pacific Islander groups, and prison populations.
- **Women's Center of Excellence:** Focuses on underserved and severe-need cis and transgender women.

The work of local CoEs is augmented by a vast network of additional services for people living with HIV in the EMA, including job training, housing, benefits counseling, and much more. The addition of funding through the EHE initiative has also allowed the EMA to **strategically fill gaps in care access and treatment and retention support for populations that have the greatest difficulty in access and remaining in services.** This includes a focus on our three focus EIIHA populations – Latinx persons, persons experiencing homelessness, and criminal justice

involved persons – along with other marginalized and underserved populations such as transgender persons, African Americans, Asian / Pacific Islanders, cis women, older adults with HIV, and persons with mental health and substance use issues. These services are specifically designed to impact **all** steps along the HIV care continuum, including through integrated services planning involving the prevention and care branches of the San Francisco Department of Public Health.

As noted above, SFDPH's LINCS (Linkage, Integration, Navigation and Comprehensive Services) program is also a core part of SF's foundation for HIV treatment. LINCS serves people newly diagnosed with HIV and prioritized individuals who are not-in-care, **including those who access care intermittently,** and supports them to engage in care. All people who newly test positive for HIV in SF are offered linkage to care and partner services through LINCS. LINCS, which is housed at SF City Clinic, maintains strong partnerships with HIV care sites throughout SF. One of LINCS' closest partnerships is with the PHAST team, which as mentioned above supports PLWH in accessing expedited care and RAPID ART. The partnerships with PHAST and other clinical care sites allow for successful linkage and engagement by lowering barriers to care and offering care coordination, system and insurance navigation, and appointment tracking.

In regard to **responding to HIV outbreaks**, the SF EMA is well-prepared to identify and respond to HIV transmission clusters and outbreaks. SFDPH offers partner services to **all** individuals newly diagnosed with HIV, including assistance with notifying partners and support in linking them to testing, prevention, and treatment as needed. These services can aid in the identification of epidemiologically linked or location-based clusters. Additionally, SFDPH uses **molecular HIV surveillance (MHS)** to identify clusters of patients who have similar HIV genotypes, with large and closely connected clusters reviewed to ensure that all individuals in the cluster are linked to care. SFDPH proactively meets with communities and organizations to keep them informed on MHS activities, an approach that is especially important given past and present harms committed by our medical, legal, and immigration systems, and to address perceptions and respond to concerns that such activities could pose risks. In addition, SFDPH has processes in place to identify and reach out to people diagnosed with HIV who do not have recent evidence of medical care, such as a viral load test, in order to offer them linkage to care. Partner services are also important as a component of STI prevention and response. SFDPH offers partner services to prioritized patients with syphilis, as well as to patients with antibiotic-resistant gonorrhea.

B. Funding for Core and Support Services

1. Service Category Plan:

a) Service Category Plan Table: Please see table in **Attachment 10.**

b) MAI Service Category Plan Narrative:

i. How MAI Services Will Address the Needs of any MAI Population Identified in the Subpopulation of Focus Section: For the FY 2025-2026 Part A fiscal year, the San Francisco EMA

is requesting a total of **$782,342** in Minority AIDS Initiative funding to specifically address the needs of **Latinx individuals living with HIV,** identified as one of our three subpopulations of focus in our EIIHA Plan above. These MAI funds will specifically support the EMA's **Mission Center of Excellence** that has been established in the heavily Latinx 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. The Center provides culturally competent, integrated, bilingual/bi-cultural medical and health services to community members living with HIV, with an emphasis on Spanish-speaking Latinx clients. In addition to supporting the cost of direct medical/ambulatory health services through a staff of five bilingual/bicultural professionals, MAI funding helps support the cost of medical case management, mental health counseling, and substance abuse 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. As required by the NOFO, local MAI funds will be used to improve HIV-related health outcomes and reduce existing racial and ethnic health disparities involving Latinx communities by providing core medical and related support services that address the unique barriers and challenges faced this population. The SF EMA's MAI services are fully consistent with epidemiologic data and identified need and are specifically designed to provide a **culturally appropriate** service option for Latinx PLWH, employing the use of **population-tailored, innovative approaches** for the disproportionately impacted Latinx community, with the goal of achieving greater levels of care retention and viral suppression within this population. Key funded subcategories within the overall MAI funding request include **$469,667** for **Latinx-focused Medical Case Management Services** and **$234,441** for bilingual/bicultural **Mental Health Services** provided by mental health professionals who understand and are reflective of the populations they serve.

ii. <u>How MAI Services Improve Latinx Health Outcomes:</u> 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 Latinx community members, in turn reducing service disparities and improving health outcomes across the region for this population. FY 2023-2024 Part A MAI funding enabled the EMA to provide critical medical, case management, and primary services to **over 320** impoverished clients of color, many of whom are transgender persons. MAI support for culturally appropriate medical case management services plays a critical role in helping low-income and disadvantaged Latinx persons understand the local HIV care system; identify and link to all needed medical and social services through culturally sensitive providers; receive ongoing support to address personal, systemic, environmental, and cultural barriers to care; and remain consistently engaged in HIV treatment on a long-term basis, in turn resulting in increased rates of HIV care retention and viral suppression. Meanwhile, Latinx-focused mental health services allow Latinx PLWH to access behavioral health support provided by professionals who are reflective of their country of origin and who understand the specific needs and challenges faced by Latinx PLWH, including confronting ongoing **stigma** related to HIV diagnosis and behaviors. Mental health services help individuals address issues that may be serving as barriers to sustaining long-term health and wellness, and specifically to remaining consistently engaged in care and on regular ART therapy.

PREVIEW Date: Oct 01, 2024 Workspace ID: WS01394483 Funding Opportunity Number: HRSA-25-054

2. Unmet Need:

Through Ryan White Part A and EHE funding, the San Francisco EMA supports a wide range of specialized, tailored programs specific designed to improve outcomes for individuals with unmet need who are: 1) late diagnosed; 2) have unmet need; and 3) are in care but not virally suppressed. Many of these interventions are listed in the EIIHA section above, which outlines a number of innovative strategies funded through both Part A and EHE funding that are specifically designed to increase HIV testing rates and normalize and broaden awareness of the importance of HIV testing, strategies that in turn reduce the number of late diagnosed persons in the EMA; engage larger numbers of persons in HIV care and supportive services; support persons in care who face specific challenges and barriers to care retention and medication adherence; and conduct specialized interventions for persons who are in care but not virally suppressed. The Resolution of Challenges table below also describes specific interventions that are in place to address the specific needs of older persons with HIV; homeless and unstably housed populations; criminal justice involved populations; and persons with complex needs. **The consistent focus of San Francisco Ryan White services is to continually support and promote early engagement in HIV care and consistent, long-term adherence to HIV treatment and medication regimens.**

- **RESOLUTION OF CHALLENGES**

Please see table beginning on the following pages.

- **EVALUATION AND TECHNICAL SUPPORT CAPACITY**

A. Clinical Quality Management (CQM)

1. Description of the CQM Process:

The San Francisco EMA maintains a well-established quality management infrastructure that enables consistent analysis and problem solving of issues related to client care and to lack of equity in regard to HIV care outcomes. The **Director of HIV Health Services,** Bill Blum, oversees the creation, implementation, and evaluation of continuous quality improvement (CQI) based on activities and timelines identified in the **HIV Health Services HIV Continuous Quality Improvement Plan.** The SF DPH **HIV Health Services Continuous Quality Improvement Committee**, comprised of members with diverse perspectives on quality of care, is responsible for selecting and implementing a targeted and specific CQI effort for Ryan White Part A funded providers annually and updating the local Quality Management Plan. The Committee also prioritizes and implements new QI projects; provides continuous QI and topical training; responds to providers' needs by utilizing the **Center for Quality Improvement and Innovation**'s (CQII) Quality Indicator measures and tools; and updates performance indicators to satisfy quality measures. The San Francisco HIV Community Planning Council includes nonaffiliated consumer members who attend the CQI quarterly meetings and provide ongoing feedback and recommendations.

Challenges & Barriers	Proposed Resolutions	Intended Outcomes	Current Status
▪ **Aftermath of COVID-19 pandemic impacting job market, particularly for behavioral health and health worker positions**	▪ Robust hiring and retention plans have been enacted and more are being planned by County and Contract CBOs including increased GF support for COLA for CBOs ▪ Training programs for paraprofessionals and professionals to create a large pool of candidates and on-going training for newer employees in the HIV field.	▪ Ensure HIV employment opportunities are commensurate with other behavioral health and health worker positions in the job market. ▪ Ensure adequate training and support for frontline employees. ▪ Respond effectively to changes in the HIV care and support system with minimal disruption for clients.	▪ Numerous behavioral Health and Health worker positions have taken multiple months to fill. ▪ On-going churn as HIV frontline workers choose to leave the field for more lucrative jobs exacerbated by high local cost of living, high recent inflation, and high city housing costs leading to longer commutes and gravitation to roles with greater telecommuting options. ▪ Numerous trainings have been put into place through SF GF, RWPA and EHE (care and prevention funding) including Front Line Organizers Group (FOG) annual boot camp, Community HIV Leadership Initiative, trainings and mentorship program and SF DPH HIV Health Services Training Program offering 1-3 monthly topical trainings.
▪ **Decreases in federal RWPA and State RWPB funding to SF EMA**	▪ To date City and County of SF (CCSF) has backfilled federal and state cuts and held HIV programs harmless from reductions.	▪ Maintain the highest possible level of ongoing client service and support by prioritizing service and support needs throughout the EMA and shifting resources as needed.	▪ The SF HIV Community Planning Council continues to monitor the situation and conduct contingency planning to prepare for a range of potential future scenarios.
▪ **Rapidly aging population of persons 50 and older with HIV**	▪ Continue to develop and expand models of enhanced geriatric assessment and care in HIV clinical settings. ▪ Expand linkages between geriatric and HIV service communities and City and County Agencies.	▪ Improved health outcomes of older PLWH. ▪ Improved access to community aging services and resources for older PLWH.	▪ Ryan White funds support Golden Compass an HIV aging specialty clinic in Positive Health Program at Zuckerberg SF General Hospital. ▪ SF DPH HIV Health Services has convened a monthly countywide multidepartment agency including

PREVIEW Date: Oct 01, 2024 Workspace ID: WS01394483 Funding Opportunity Number: HRSA-25-054

Challenges & Barriers	Proposed Resolutions	Intended Outcomes	Current Status
	▪ Expand consumer involvement in designing and implementing effective support programs for older PLWH.		Mayor's Office of Community Housing Development (which administers HOPWA), and Human Services Agency, Division of Disability and Aging Services to strengthen program linkages and referrals and to expand services for HIV+ services.
▪ **Continued high impact of HIV among people experiencing homelessness (PEH) / housing instability**	▪ HIV+ PEH are one of the four priority populations of focus of SF EHE programming and funding in several programs. ▪ SFDPH incorporates training and TA on enhanced identification and service to PEH PLWH in ongoing subcontractor support activities.	▪ Earlier identification and linkage to care of homeless persons with HIV. ▪ Expanded long-term retention in care to enhance viral suppression outcomes. ▪ Improved access to safe and affordable housing with behavioral support services to preserve health and wellness. ▪ Provision of multiple services in accessible, culturally appropriate settings.	▪ SF HHS currently supports numerous programs focused on PEH with RWPA, EHE and SF GF including POP-UP, an extremely low threshold one-stop-shop medical clinic offering drop-in medical care as well as housing focused intensive case management for PEH; ▪ SF DPH with EHE funded has rolled out LAI (long acting injectable) ART clinics with a focus on prioritizing PEH HIV+. ▪ SF DPH HHS services began a health equity CQI process in 2022 focused on eliminating disparity of viral load suppression for PEH with involvement of over 20 DPH and community based ambulatory care and medical case management providers. ▪ SF HIV Community Planning Council receives periodic reporting on EHE activities to ensure the PEH population is having its needs met and services are coordinated with RWPA system of care.

PREVIEW Date: Oct 01, 2024 Workspace ID: WS01394483 Funding Opportunity Number: HRSA-25-054

Challenges & Barriers	Proposed Resolutions	Intended Outcomes	Current Status
▪ **Need to ensure long-term care retention and medication adherence for persons with complex needs**	▪ Continue to utilize medical and non-medical case management staff to assess client needs and identify and address barriers to care. ▪ Develop new methods for pro-actively identifying and working with clients who are at risk of falling out of care. ▪ Explore new methods for expanded involvement of consumers and peers in clinic-based client retention support roles.	▪ Ensure ongoing, long-term medication adherence and care retention to preserve and expand high levels of viral suppression and continue progress toward reduced HIV cases. ▪ Address long-term medication fatigue, particularly among high-risk populations such as young people, transgender persons, homeless persons, active substance users, and persons with mental illness.	▪ SFDPH supports subcontracted agencies in developing new methodologies for pro-actively identifying and supporting clients at risk of dropping out of care, including targeting long-term clients who are not virally suppressed ▪ The SF HIV Planning Council prioritizes Part A funding to support long-term care retention and medication adherence activities. ▪ SF HHS CQI activities ensure that all ambulatory care and medical case management agencies continue to improve viral load suppression for their populations. ▪ LAI ART clinical staff, funded with EHE and RWPA, are being made available to patients with difficulty achieving daily oral medication adherence.
▪ **Relinkage and maintenance in care for justice involved clients leaving county jail system**	▪ Expedited pathways and navigation services will support justice involved clients to enroll or be repatriated to their HIV care clinics.	▪ Elimination of disparity of health outcomes (viral load suppression) in justice involved clients from that of the general population. ▪ Maintenance of care continuity through linkage and appointment availability soon after release.	▪ RWPA Center of Excellence HIVIS currently has navigation services that have been augmented through EHE funding ▪ SF HHS has begun receiving TA from HAB as part of the EMA's "Big Bet" focusing on justice involved clients ▪ A quick reentry clinic has been established in SF DPH primary care clinic that sees the largest census of PLWH and they have begun to prioritize clients about to discharged from jail.

To effectively track and address local HIV-related care and outcomes disparities, several critical aspects of care are monitored throughout each contract year, including primary care health QI outcomes, client services data, The San Francisco EMA utilizes the HRSA HAB performance measures tracked through ARIES. Reports on the various performance measures are generated on a routine basis and delineate both the aggregate data for the EMA and agency-specific data for the Centers of Excellence and other core medical services programs. This data allows the EMA to assess tracking of health outcomes and evaluate system-wide or agency-specific issues in both client care and data collection. System-wide issues are discussed with the Director of HIV Health Services, the Quality Improvement Coordinator, data collection specialists at HIV Health Services, and providers at quarterly CQI meetings. These meetings serve as a forum for discussing care-related issues and performance measures and are attended by over **30** representatives from more than **15** DPH and community HIV care clinics, along with consumer members and consulting staff. Additionally, ARIES-generated QI data are utilized to measure program performance objectives standardized across several service categories such as Ambulatory/Outpatient Health Services, Medical Case Management, Mental Health Services, Hospice, and others. Additional CQI HIV work groups from other HRSA service categories are convened at least **annually** to consider and prioritize specific CQI activities.

As noted above, key coordination and oversight of the local QM process is carried out by the Quality Improvement Coordinator, who has responsibility for planning and implementation of activities related to the EMA's quality management program, which is focused on achieving health equity across all HIV subpopulations. Additional consultants conduct a variety of activities such as developing training curricula for new standards of care; leading and presenting trainings in standards of care and other relevant topics. To track indicators, HIV Health Services establishes benchmarks with each agency at the beginning of each contract period and provides training and technical assistance to ensure that agencies understand and are able to meet ARIES data reporting requirements. HHS has also disseminated an ARIES Procedural Guidelines for Client Outcome Objectives Reportage to all primary care and medical case management service providers. HIV Health Services aggregates agency data to track progress toward stated indicators and discusses variations with agencies when they are identified. HHS also works with agencies to collaboratively develop remedial responses to ensure adherence to quality standards when needed.

The San Francisco EMA's well-established Quality Management infrastructure enables consistent analysis and problem solving of issues related to client care. The Director of HIV Health Services oversees the creation, implementation, and evaluation of QI activities that are in turn supervised and managed on a day-to-day basis by the HIV Health Services Assistant Director, with support from the Administrative Analyst, the HHS Quality Improvement Coordinator, and the ARIES Site Manager. Under these individuals' supervision, and in collaboration with providers, quality components are developed and implemented in collaboration with other services and administrative staff from the selected programs. Additionally, consultants with a wide range of diverse skills and expertise may support the QM program through the provision of services such as training, technical assistance, program evaluation, and administrative support.

2) <u>Description of CQI Activity:</u>

The mission of the San Francisco Department of Public Health (SFDPH) is to protect and promote the health and well-being of all San Francisco residents. In many ways, San Franciscans are healthier than Americans in many other parts of the country. However, the same cannot be said of African Americans, who have persistently poorer health outcomes than their fellow residents in a wide array of measures and who have been disproportionately affected by HIV/AIDS for decades. Fortunately, due to CQI work over the past 12 years, the disparity in viral suppression for the Black and African American community has now been **eliminated**. From 2012 to 2022, viral suppression in the Black and African American community improved from **67%** to **83%,** with the **16%** improvement representing the largest increase among all race/ethnic groups. The table below describes a recent effort to improve viral suppression outcomes for African American and homeless /unstably housed populations in the SF EMA. While local CQI work has eliminated the disparity, it remains a "watch metric", with quarterly reviews conducted to ensure that it does not re-emerge.

Methodology Used	Related Service Categories	Key Activities	Timeline	Persons Responsible	Intended Outcomes
Collaborating with community partners to address viral load disparity among African American and homeless / unstably housed PLWH, including through the development of culturally appropriate client outreach and support approaches	Outpatient / ambulatory medical services; medical and non-medical case management; mental health services; housing services	▪ Consistent panel clean-up ▪ Identification of and outreach to clients with unsuppressed viral loads ▪ Client-focused interventions to increase care retention and medical adherence ▪ Referrals to specialty care and support services	2022 to Present	Acting Assisting Director of HIV Health Services; Health Care Analyst; CQI Team	▪ Increased care retention, including higher rates of twice-yearly medical visits ▪ Increased viral suppression rates across the target populations

PREVIEW Date: Oct 01, 2024 Workspace ID: WS01394483 Funding Opportunity Number: HRSA-25-054

ENDNOTES

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[1] US Census Bureau, *California QuickFacts*, Marin, San Francisco, & San Mateo Counties, Accessed September 1, 2024.
[2] California Department of Health Services Office of AIDS, *California HIV Surveillance Report 2022*, Sacramento, CA, Updated 2024 and US Centers for Disease Control and Prevention, Estimated HIV incidence and prevalence in the United States, 2018-2022, *HIV Surveillance Report*, Supplemental Report, Vol. 29, No. 1, 2024.
[3] California Department of Health Services Office of AIDS, Op. Cit.
[4] New York City Department of Health and Mental Hygiene, *HIV Surveillance Annual Report, 2022* New York, NY, November 2023.
[5] California Department of Health Services Office of AIDS, Op. Cit.
[6] Estimate of total PLWH living at 300% of poverty or below based on 98.2% rate of PLWH receiving Part A services living at or below 300% of poverty in FY 20237-24 (n=6,076) plus conservatively estimated 27.6% rate of 300% at or below FPL for all other PLWH (2,206 of 7,992 remaining PLWH)(poverty same as overall region-wide rate).
[7] National Low Income Housing Coalition, *Out of Reach 2024,* Washington, DC, 2024.
[8] US Department of Housing and Urban Development (HUD), FY 2021 Fair Market Rent Documentation System, Accessed October 2024.
[9] Source: 2024 Point-in-Time Homeless Counts for Marin, San Francisco, and San Mateo Counties.
[10] Chen S, Fitzpatrick A, Beheraj K, Share of San Francisco Residents Who are Uninsured, 2022, *Axios San Francisco,* August 12, 2024, *https://www.axios.com/local/san-francisco/2024/08/12/health-insurance-rates-california-bay-area*
[11] San Francisco Department of Public Health, Population Health Division, HIV Epidemiology Section, *HIV Epidemiology Annual Report 2023*, San Francisco, CA, September 2024.
[12] McNeil, D, San Francisco is changing the face of AIDS treatment, *New York Times*, October 5, 2015.
[13] Ibid.
[14] Hartman L, California achieves lowest uninsured rate ever in 2022, California Health Care Foundation, November 6, 2023.
[15] San Francisco Department of Public Health, Population Health Division, HIV Epidemiology Section, Op. Cit.
[16] California Department of Health Services, *Ending the Epidemics: Integrated Statewide Strategic Plan 2022-2026*, Sacramento, CA, 2022, https://www.cdph.ca.gov/Programs/CID/DOA/Pages/Strategic-Plan/Main.aspx
[17] San Francisco Department of Public Health, *San Francisco's Integrated Ending the Epidemics Plan: 2024-2026 Strategies and Activities*, San Francisco, CA, 2024.

PREVIEW Date: Oct 01, 2024 Workspace ID: WS01394483 Funding Opportunity Number: HRSA-25-054