File No. 180895 Committee Item No. 6
Board Item No. 13

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget & Finance Committee **Date** September 27, 2018

Board of Supervisors Meeting **Date** October 16, 2018

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Completed by: Linda Wong **Date** September 26, 2018
Completed by: Linda Wong **Date** October 1, 2018

FILE NO. 180895 RESOLUTION NO.

[Apply for Grant Application - Health Resources Services Administration - Ryan White Act HIV/AIDS Emergency Relief Grant Program - $16,202,223]

Resolution authorizing the Department of Public Health to submit an application to continue to receive funding for the Ryan White Act HIV/AIDS Emergency Relief Grant Program grant from the Health Resources Services Administration; and requesting $16,202,223 in HIV Emergency Relief Program funding for the San Francisco Eligible Metropolitan Area for the period of March 1, 2019, through February 28, 2020.

WHEREAS, San Francisco Administrative Code requires Board review of proposed annual or otherwise recurring grant applications of $5,000,000 or more prior to their submission; and

WHEREAS, San Francisco Department of Public Health (SFDPH) is currently a recipient of the "Ryan White Act HIV/AIDS Emergency Relief Grant Program" grant in the amount of approximately $15,430,689 from the Health Resources Services Administration (HRSA) for FY2018; and

WHEREAS, For this round of funding, SFDPH was instructed by HRSA to submit an application request in the amount of $16,202,223; and

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

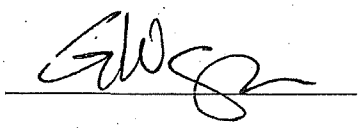
WHEREAS, Ordinance No. 265-05 requires that City Departments submit applications for approval at least 60 days prior to the grant deadline for review and approval; and

WHEREAS, HRSA released the application guidance on June 4, 2018, with a due date of September 21, 2018, allowing 77 business days for the entire process; and

WHEREAS, In the interest of timeliness, SFDPH is making this request for approval by submitting its most recent draft of the grant application, also including supporting documents as required, all of which are on file with the Clerk of the Board of Supervisors in File No. 180895, which is hereby declared to be part of the Resolution as if set forth fully herein; now, therefore, be it

RESOLVED, That the Board of Supervisors hereby approves SFDPH's application submission to HRSA for the "Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A)" grant for the funding period of March 1, 2019, through February 28, 2020, to be submitted no later than September 21, 2018.

RECOMMENDED:



Greg Wagner

Acting Director of Health

City and County of San Francisco
London N. Breed
Mayor

San Francisco Department of Public Health
Greg Wagner
Acting Director of Health

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

Funding Criteria

The San Francisco Department of Public Health (SFDPH) is currently a recipient of the Ryan White HIV/AIDS HIV Emergency Relief Grant Program (Ryan White Programs, Part A) in the amount of $15,430,689 from the Health Resources Services Administration (HRSA). The Part A grant is awarded to the San Francisco Eligible Metropolitan Area which is comprised of the City and County of San Francisco, Marin County, and San Mateo County.

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

Department's Most Recent Draft of Grant Applications Materials

Please see Attachment A for the SFDPH's most recent draft of application materials. SFDPH's most recent application was submitted to HRSA on October 30, 2017 for the funding period of March 1, 2018 to February 28, 2019. We have received the application guidance from HRSA for the March 1, 2019 to February 28, 2020 funding period on June 4, 2018 with an application due date of September 21,2018.

Anticipated Funding Categories

The Part A funds are awarded to SFDPH on an annual basis to cover a multitude of health services to HIV positive persons residing in the three counties within the San Francisco EMA.

Please see Attachment B for an example of the FY 2018-2019 Planned Service Mode Allocations for the San Francisco EMA. The service modes are defined by HRSA. The San Francisco HIV Health Services Planning Council, a citizen advisory board, is responsible for determining the priorities and the allocation of funds within each HRSA service mode for the San Francisco EMA.

Comments from Relevant Citizen Advisory Board

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

FY 2018 Part A Planning Council/Planning Body Membership Roster

Date the form was completed?	8/20/2018
What is the total authorized/prescribed number of PC/PB members according to PC/PB By-laws (**minimum #**)?	0
How many individuals are currently serving PC/PB members?	38
What is the number of vacancies, if any?	12
What percentage of PC/PB members are non-aligned consumers?	32%
Do at least two members of the PC/PB publicly disclose their HIV status?	yes
Per the most current PC/PB bylaws are there term limits?	no
If there are term limits, what are they?	

Name (use an * to self-identify)	PC Position	Agency Affiliation	Gender	Race/Ethnicity	Membership Category	Member since?	Non-aligned (1 for yes; 0 for No)	Term(s)
Chuck Adams	PLWHA Representative		Male	White	Affected Communities, including PLWH and historically underserved subpopulations	2015	1	3
Orin Allen	PLWHA Representative		Male	Black or African American	Affected Communities, including PLWH and historically underserved subpopulations	2017	1	1
Margot Antonetty	Member	SFDPH Housing & Urban Health	Female	White	Local Public Health Agencies	2000	0	11
Bill Blum	Member	SFDPH HHS	Male	White	Local Public Health Agencies	2016	0	2
Jackson Bowman	Member	Huckleberry Youth Services	Transgender	White	Part D, or if none present, representatives of organizations addressing the needs of children, youth, and families with HIV	2016	0	2
Ben Cabangun	Chair	Asian & Pacific Islander American Health Forum	Male	Asian	Non-elected community leaders	2016	0	2
Cesar Cadabes	PLWHA Representative	UCSF	Male	Hispanic or Latino	Non-elected community leaders	2016	0	2
Ed Chitty	Member	Kaiser	Male	White	Healthcare providers, including Federally Qualified Health Centers	2016	0	2
Billie Cooper	PLWHA Representative		Transgender	Black or African American	Affected Communities, including PLWH and historically underserved subpopulations	2006	1	7
Zachary Davenport	Member	SFDPH Adult Behavioral Services	Unknown	White	Mental Health	2017	0	1
Michael Discepola	Member	San Francisco AIDS Foundation	Male	White	Substance Abuse Providers	2016	0	2
Cicily Emerson	Member	Marin DPH	Female	White	Local Public Health Agencies	2009	0	6
Elaine Flores	Member		Female	Hispanic or Latino	Non-elected community leaders	2015	0	3
Wade Flores	PLWHA Representative		Male	Hispanic or Latino	Affected Communities, including PLWH and historically underserved subpopulations	2005	1	7
Matt Geltmaker	Member	San Mateo DPH	Male	White	Local Public Health Agencies	2009	0	6
David Gonzalez	Member	Homeless Youth Alliance	Male	Hispanic or Latino	Social Service Providers, including housing and homeless services providers	2016	0	2
Dean Goodwin	Chair	SFDPH HHS	Male	White	Local Public Health Agencies	2016	0	2
Liz Hall	Member	CA State Office of AIDS	Female	Hispanic or Latino	State Part B Agency	2013	0	3

Paul Harkin	Member	Glide	Male	White	Social Service Providers, including housing and homeless services providers	2016	0	2
Ron Hernandez	PLWHA Representative		Male	Asian	Affected Communities, including PLWH and historically underserved subpopulations	2012	1	4
Bruce Ito	Member	Mayor's Office of Housing & Community Development	Male	Asian	Social Service Providers, including housing and homeless services providers	2012	0	4
Lee Jewell	PLWHA Representative		Male	White	Affected Communities,	2008	1	7
Dominique Johnson								1
Thomas Knoble	Chair	SFDPH CHEP (Community Health Equity & Promotion)	Male	Hispanic or Latino	Local Public Health Agencies	2018	0	1
Kevin Lee	Member	Marin DPH	Male	Asian	Local Public Health Agencies	2016	0	2
T.J. Lee	PLWHA Representative		Male	White	Affected Communities,	2014	1	4
Jessie Murphy	Member	Alliance Health Project	Female	White	Mental Health	2016	0	2
Irma Parada	Member	Jail Health Services	Female	Hispanic or Latino	Representatives of/or formerly-incarcerated PLWH	2017	0	1

FY16 RWHAP Part A & MAI Allocations Report

Section A: Identifying Information
San Francisco, California
Dean Goodwin
415-437-6278
Dean.Goodwin@sfdph.org

Detailed instructions for completing and submitting your report can be downloaded from the HRSA Electronic Handbook: https://grants.hrsa.gov/webexternal/Login.asp

Section B: Reporting Year Award Information	
1. Part A Grant Award Amount	$14,663,442
2. MAI Grant Request / Award Amount	$767,247
3. Total Part A Funds	**$15,430,689**

Section C: Allocation Categories	1. Part A Award		2. MAI Award		3. Combined Total	
	Amount	Percentage	Amount	Percentage	Amount	Percentage
1. Core Medical Services Subtotal [1] (see CHECKLIST)	**$8,025,414**	**60.98%**	**$690,522**	**100.00%**	**$8,715,936**	**62.92%**
a. Outpatient /Ambulatory Health Services	$1,067,556	8.11%	$14,632	2.12%	$1,082,188	7.81%
b. AIDS Drug Assistance Program (ADAP) Treatments		0.00%		0.00%	$0	0.00%
c. AIDS Pharmaceutical Assistance (local)		0.00%		0.00%	$0	0.00%
d. Oral Health Care	$806,269	6.13%		0.00%	$806,269	5.82%
e. Early Intervention Services	$31,461	0.24%		0.00%	$31,461	0.23%
f. Health Insurance Premium & Cost Sharing Assistance	$41,193	0.31%		0.00%	$41,193	0.30%
g. Home Health Care	$271,003	2.06%		0.00%	$271,003	1.96%
h. Home and Community-based Health Services		0.00%		0.00%	$0	0.00%
i. Hospice Services	$784,687	5.96%		0.00%	$784,687	5.66%
j. Mental Health Services	$1,762,875	13.39%	$133,802	19.38%	$1,896,677	13.69%
k. Medical Nutrition Therapy		0.00%		0.00%	$0	0.00%
l. Medical Case Management (incl. Treatment Adherence)	$3,173,592	24.11%	$453,982	65.74%	$3,627,574	26.19%
m. Substance Abuse Services - outpatient	$86,778	0.66%	$88,106	12.76%	$174,884	1.26%
2. Support Services Subtotal	**$5,136,041**	**39.02%**	**$0**	**0.00%**	**$5,136,041**	**37.08%**
a. Case Management (non-Medical)	$1,954,108	14.85%		0.00%	$1,954,108	14.11%
b. Child Care Services		0.00%		0.00%	$0	0.00%
c. Emergency Financial Assistance	$1,097,040	8.34%		0.00%	$1,097,040	7.92%
d. Food Bank/Home-Delivered Meals	$121,527	0.92%		0.00%	$121,527	0.88%
e. Health Education/Risk Reduction		0.00%		0.00%	$0	0.00%
f. Housing Services	$916,107	6.96%		0.00%	$916,107	6.61%
g. Legal Services	$284,620	2.16%		0.00%	$284,620	2.05%
h. Linguistics Services		0.00%		0.00%	$0	0.00%
i. Medical Transportation Services	$18,534	0.14%		0.00%	$18,534	0.13%
j. Outreach Services	$267,677	2.03%		0.00%	$267,677	1.93%
k. Psychosocial Support Services	$476,428	3.62%		0.00%	$476,428	3.44%
l. Referral for Health Care/Supportive Services		0.00%		0.00%	$0	0.00%
m. Rehabilitation Services		0.00%		0.00%	$0	0.00%
n. Respite Care		0.00%		0.00%	$0	0.00%
o. Substance Abuse Services - residential		0.00%		0.00%	$0	0.00%
p. Treatment Adherence Counseling		0.00%		0.00%	$0	0.00%
3. Total Service Allocations	**$13,161,455**	**100.00%**	**$690,522**	**100.00%**	**$13,851,977**	**100.00%**
4. Non-services Subtotal	**$1,501,987**	**10.24%**	**$76,725**	**10.00%**	**$1,578,712**	**10.23%**
a. Clinical Quality Management [2] (see CHECKLIST)	$350,000	2.39%		0.00%	$350,000	2.27%
b. Grantee Administration [3] (see CHECKLIST)	$1,151,987	7.86%	$76,725	10.00%	$1,228,712	7.96%
5. Total Allocations (Service + Non-service) [4] (see CHECKLIST)	**$14,663,442**	**100.00%**	**$767,247**	**100.00%**	**$15,430,689**	**100.00%**

FOR OFFICE USE ONLY:

☐ Grantee received waiver for 75% core medical services requirement.

PUBLIC BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB number. The OMB control number for this project is 0915-0318. Public reporting burden for this collection of information is estimated to be 1.5 hours per response. These estimates include the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments to HRSA Reports Clearance Officer, Health Resources and Services Administration, Room 10-33, 5600 Fishers Lane, Rockville, MD. 20857.

LEGISLATIVE REQUIREMENTS CHECKLIST

INSTRUCTIONS: Grantees and Project Officers should use the following table to determine whether or not the following legislative requirements have been met. Unlike the Allocations Report which shows individual allocations as a percentage of total allocations, this table shows allocations as a percentage of award for specific cateogories as outlined in the Ryan White HIV/AIDS Treatment Extension Act of 2009.

REQUIREMENT: 75% of your total award must be allocated to core medical services, after reserving funds for administration and clinical quality management

When reporting Core Medical Services allocations, the Current FY totals in Section C, Row 1 of the Allocation Report for PART A AWARD and MAI AWARD columns do not necessarily need to be 75% of each individual award as long as the combined total meets the 75% minimum requirement. The exception to this requirment is only for those grantees that requested, and were approved by HRSA, for a Part A Core Medical Services Waiver.

62.9%

To the right in red, is the percentage of your Current Fiscal Year Core Medical Services allocations divided by your Total Part A Award less CQM and Grantee Administration allocations (F17 / F48). Please check to make sure this percentage is 75% or greater.

REQUIREMENT: No more than 5% of your total award or $3 million (whichever is smaller) can be allocated to clinical quality management.

When reporting Clinical Quality Management allocations, the Current FY totals in Section C, Row 4a of the Allocations Report for PART A AWARD and MAI AWARD columns do not necessarily need to be meet this requirement as long as the combined total meets the 5% or $3 million (whichever is smaller) requirement.

$771,534 (Capped Amount)

To the right in red, is the maximum (Capped Amount) you can allocate on Clinical Quality Management (the lessor of B12 * .05 or $3 million) as well as the amount of Current Fiscal Year dollars allocated (CQM Allocations) on Clinical Quality Management (F50). Please check to make sure your Allocations do not exceed your Capped Amount.

$350,000 (CQM Allocations)

REQUIREMENT: No more than 10% of your total award can be allocated to grantee administration.

When reporting Grantee Administration allocations, the Current FY totals in Section C, Row 4b of the Allocations Report for PART A AWARD and MAI AWARD columns do not necessarily need to be meet this requirement as long as the combined total meets the 10% or less requirement.

8.0%

To the right in red, is the percentage of your Current Fiscal Year Grantee Administration allocations divided by your Total Part A Award (F51 / B12.) Please check to make sure this percentage is not greater than 10%.

WORKING TOWARD ZERO:
SAN FRANCISCO EMA FY 2018 RYAN WHITE PART A
COMPETING CONTINUATION APPLICATION NARRATIVE

INTRODUCTION

The San Francisco Eligible Metropolitan Area (EMA) requests a total **$16,601,550** in Fiscal Year 2018 Ryan White Part A Formula and Supplemental funding for our region to continue to meet the ongoing local crisis of HIV infection. Requested funds will ensure a seamless, comprehensive, and culturally competent system of care focused on the complementary goals of reducing inequities and disparities in HIV care access and outcomes and ensuring parity and equal access to primary medical care and support services for all residents in the region. The FY 2018 Part A Service Plan described in our application strikes a balance between providing an integrated range of intensive health and supportive services for complex, severe need, and multiply diagnosed populations, and expanding and nurturing the self-management and personal empowerment of persons living with HIV. The Plan also highlights the expanded integration with HIV outreach, testing, linkage, and care retention services and incorporates the perspectives and input of a broad range of consumers, providers, and planners from across the region, as well as findings of key data sources described below. The FY 2018 Part A application presents an effective strategy to both preserve and advance a tradition of HIV service excellence in the San Francisco EMA.

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

identical to those of the county in which it is located. The unification of city and county governments under a single mayor and Board of Supervisors allows for a streamlined service planning and delivery process.

According to the US Census, as of July 1, 2016, the total population of the San Francisco EMA is **1,896,335**.[1] This includes a population of **260,651** in Marin County, **870,887** in San Francisco County, and **764,797** in San Mateo County, with widely varying population densities within the three regions. While the density of Marin County is **501** persons per square mile, the density of San Francisco County is **18,649 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 **1,703** persons per square mile is still more than ten times lower than its neighbor county to the north. These differences necessitate varying approaches to HIV care in the EMA.

The geographic diversity of the San Francisco EMA mirrors the diversity of the people who call the area home. Over **half** of the EMA's residents (**55.3%**) are persons of color, including Asian/Pacific Islanders (**29.6%**), Latinos (**19.2%**), and African Americans (**4.1%**). In San Francisco, persons of color make up **59.1%** of the total population, with Asian residents alone making up nearly **one-third** (**30.1%**) 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 immigrants, including large numbers of Japanese, Vietnamese, Laotian, and Cambodian residents. A large number of Latino immigrants also reside in the EMA, including natives of Mexico, Guatemala, El Salvador, and Nicaragua. EMA-wide, **31.6%** of residents were born outside the US and **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**

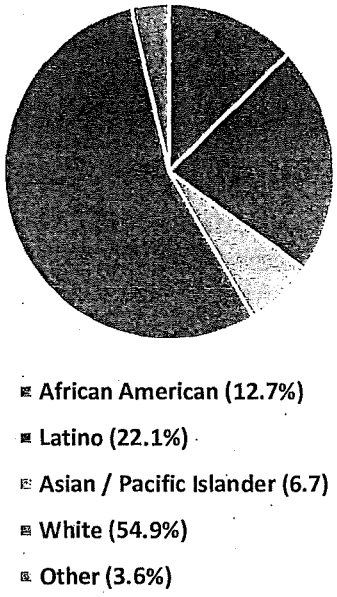
b. Socioeconomic Characteristics of Persons Affected by HIV:

i. Demographic Data: Nearly 35 years into the HIV epidemic, the three counties of the San Francisco region continue to be devastated by HIV – an ongoing crisis that has exacted an enormous human and financial toll on our region. As of December 31, 2015, over **41,000** cumulative cases of HIV had been diagnosed in the region, and over **23,000** persons have died as a result of the local HIV epidemic. As of December 31, 2016, a total of **15,691** persons were living with HIV in the region's three counties, for a region-wide HIV infection incidence of **843.3** cases per 100,000 persons, meaning that roughly **1 in every 120 residents of the San Francisco region is now living with HIV.**

At the epicenter of this continuing crisis lies the City and County of San Francisco, the city hardest-hit during the initial years of the AIDS epidemic. Today, the City of San Francisco continues to have the nation's highest per capita prevalence of cumulative AIDS cases,[2] and HIV remains the leading cause of death in the city among all age groups, as it has been for nearly two decades.[3] As of the end of 2016, at total of **13,216** San Franciscans

were living with diagnosed HIV infection, representing **84.2%** of all persons living with HIV in the three-county region, for a staggering citywide prevalence of **1,517.5 cases of HIV per 100,000.** A total of at least **223** new cases of HIV infection were diagnosed in San Francisco in calendar year 2016 alone,

Figure 1. Persons Living with HIV in San Francisco EMA by Ethnicity as of December 31, 2016

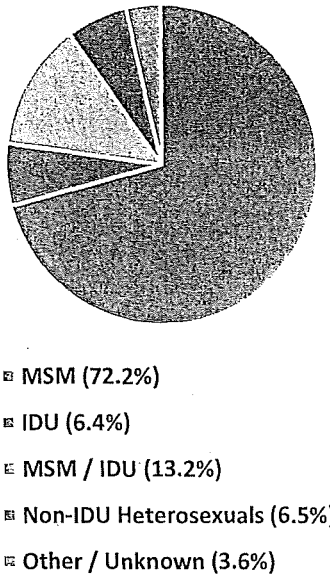


Race / Ethnicity: Reflecting the ethnic diversity of our region, the local HIV caseload is distributed among a wide range of ethnic groups. Because the local HIV epidemic had its first broad impact on white men who have sex with men (MSM), the majority of persons living with HIV (PLWH) are white (**54.9%**). Another **12.7%** of cases are among African Americans; **22.1%** are among Latinos; and **6.7%** are among Asian / Pacific Islanders (see **Figure 1**). A total of **7,074** persons of color were living with HIV infection in the three-county region as of December 31, 2016, representing **45.1%** of all persons living with HIV. African Americans are significantly over-represented in terms of HIV infection, making up **12.7%** of all persons living with HIV while comprising only **4.3%** of the area's population. This disproportion is even greater among **women** with HIV, a group in which African American women make up **38%** of all PLWH while comprising **4.1%** of the region's total female population. Additionally, among the region's hard-hit transgender population, persons of color make up **80.1%** of all PLWH, including a population that is **32.7%** African American, **32.7%** Latino, and **10.2%** Asian / Pacific Islander.

Transmission Categories: The most important distinguishing characteristic of the HIV epidemic in the San Francisco region is that HIV remains primarily a disease of men who have sex with men (MSM). In other regions of the US, the proportionate impact of HIV on MSM has declined over time as populations such as women, injection drug users, and heterosexual men have been increasingly affected by the epidemic. While these groups have been impacted in our region as well, their representation as a proportion of total PLWH has remained relatively low. Through December 31, 2016, fully **85.4%** of persons living with HIV in our region were MSM (**13,398**), including **11,323** men infected with HIV through MSM contact only (**72.2%** of all PLWH) and **2,075** MSM who also injected drugs (**13.2%** of all PLWH) (see **Figure 2**). This represents an **increase** from the end of 2008, when MSM made up **82.3%** of all PLWH. By comparison, only **41.2%** of PLWH in New York City as of December 31, 2015 were listed as infected through MSM contact - less than half the MSM infection burden of the San Francisco EMA.[4] Factors underlying this difference include the high proportion of gay and bisexual men living in the region; the large number of local long-term MSM HIV survivors; growing rates of STD infection among MSM; and

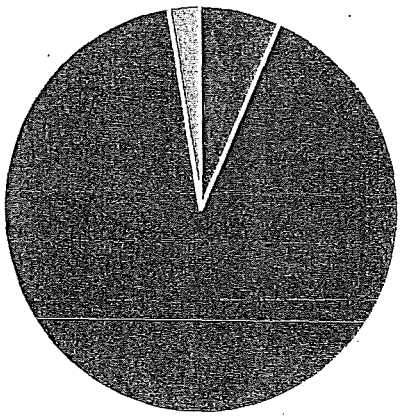
relatively high local drug use rates. Other significant local transmission categories include heterosexual persons who inject drugs (PWID) (**6.4%** of PLWH) and non-PIWD heterosexuals (**6.5%**). The proportion of heterosexual HIV cases in the San Francisco EMA is believed to be the lowest of any EMA in the US.

Figure 2. Persons Living with HIV in San Francisco EMA by Transmission Category as of December 31, 2016

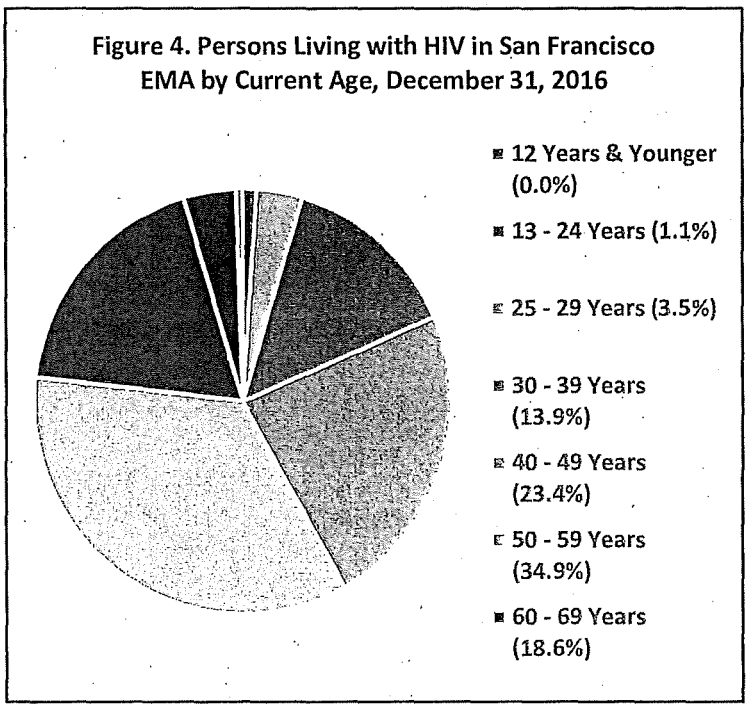


Gender: Reflecting the high prevalence of HIV among men who have sex with men, the vast majority of those living with HIV in the San Francisco region (**90.8%**) are men (see **Figure 3**). Only **6.7%** of PLWH in the region are women, over **70%** of whom are women of color. Among African Americans living with HIV, **15.2%** are women. 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 HIV region or jurisdiction in the nation. Because of their high representation within the San Francisco population, **transgender persons** also make up a significant percentage of PLWH, with at least **395** transgender individuals - the vast majority of them male-to-female – living with HIV as of December 31, 2016, representing **2.5%** of the region's PLWH caseload.

Figure 3. Persons Living with HIV in San Francisco EMA by Gender as of December 31, 2016



Current Age: The majority of persons living with HIV in the San Francisco region are age 50 and above. This is attributable to the long history of the epidemic in our region - resulting in a large proportion of long-term survivors - as well as to the region's hard-fought success in bringing persons with HIV into care and maintaining their health of time. As of December 31, 2016, **nearly 2 in every 5** persons living with HIV in the SF EMA (**58.1%**) are age 50 or older, including **5,484** PLWH between the ages of 50 and 59; **2,911** PLWH between the ages of 60 and 69; **641** PLWH between the ages of 70 and 79; and **78** PLWH who are age 80 or older (see **Figure 4**). In the city of San Francisco, persons 50 and older make up **63%** of all persons living with HIV. Between December 2009 and



December 2016 alone, the number of persons 50 and over living with HIV increased by **41%** within the region (from **41.2%**) while the number of PLWH 65 and older increased by **88.2% over the last 24 months alone**. This 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. Persons between the ages of 30 and 49 make up **37.3%** of all PLWH in the region (n=**5,835**) while young adults ages 25 - 29 make up **3.5%** (n=**550**). A total of **169** young people between the ages of 13 and 24 are estimated to be living with HIV in the region, constituting **1.1%** of the PLWH population. However, young people ages 13-24 made up **14.0%** of all new HIV cases identified in calendar year 2016, pointing to a growing HIV incidence within this population. Only **5** children age 12 and under are living with HIV in the region, and **no** new AIDS cases were diagnosed among this group between January 1, 2010 and December 31, 2016.

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

<u>Poverty:</u> The problem of poverty presents a daunting challenge to the HIV care system. According to the US Census, the average percentage of persons living at or below federal poverty level stands at **12.6%** for the entire San Francisco region. Using this data, SF DPH projects that at least **716,814** individuals in the San Francisco region are living at or below 300% of Federal Poverty Level, which translates to **37.8%** of the overall region population lacking resources to cover all but the most basic expenses. **However, because of the high cost of living in the San Francisco Bay Area, persons at 300% of poverty or below have a much more difficult time surviving in our area than those living at these income levels in other parts of the U.S.** Analyzing data from the San Francisco AIDS Regional Information and Evaluation System (ARIES), the SF region's client-level data system, it is estimated that at least **60.1%** of all persons living with HIV in the San Francisco region (n=**9,430**) are living at or below 300% of the 2017 Federal Poverty Level (FPL) including persons in impoverished households, while **96.6%** of Part A-funded clients live at or below 300% of poverty.[5] ARIES data also reveals that **62.4%** of active Ryan White Part A clients in the San Francisco region are currently living at or below 100% of FPL while another **27.8%** are living between 101% and 200% of FPL. HIV-infected

persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **$249 million** in Part A and non-Part A HIV-related expenditures in the San Francisco region each year[6].

Housing and Homelessness: Housing is an indispensable to ensure good health outcomes for persons with HIV. Without adequate, stable housing it is highly challenging for individuals to access primary care; maintain combination therapy; and preserve overall health and wellness. These issues are more critical for persons with co-morbidities such as substance addiction and/or mental illness, since maintaining sobriety and medication adherence is much more difficult without stable housing. Homelessness is also a critical risk factor for HIV, with one study reporting HIV risk factors among **69%** of homeless persons.[7]

Figure 5.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs, 2017

County	Hourly Wage to Rent a 2-Bdrm. Apt. at HUD Fair Market Rents
San Francisco County, CA	$ 58.04
Marin County, CA	$ 58.04
San Mateo County, CA	$ 58.04
Santa Clara County, CA	$ 42.69
Alameda County, CA	$ 41.79
Contra Costa County, CA	$ 41.79
Honolulu County, HI	$ 38.12
Nassau County, NY	$ 36.12
Suffolk County, NY	$ 36.12
Santa Cruz County, CA	$ 35.19

Because of the prohibitively high cost of housing in the San Francisco region and the shortage of affordable rental units, the problem of homelessness has reached crisis proportions, creating formidable challenges for organizations seeking to serve HIV-infected populations. According to the National Low Income Housing Coalition's *Out of Reach 2017* 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 three least affordable counties in the nation** in terms of the minimum hourly wage needed to rent an average two-bedroom apartment, which currently stands at **$58.04 per hour** (see **Figure 5**).[8] This means that an individual must make at least $58 an hour to afford a 2-bedroom apartment, and represents an increase of **31.8% in the last 12 months alone**. Meanwhile, according to the HUD Fair Market Rent Documentation System, the San Francisco metropolitan region has the **highest HUD-established Fair Market Rental rate in the nation** at **$2,014** for a studio apartment and **$2,459** for a 1-bedroom apartment, which represents the amount needed to "pay the gross rent of privately owned, decent, and safe rental housing of a modest nature".[9] An analysis of 2016-2017 ARIES data revealed that only about **two-thirds** Ryan White Part A clients were stably housed during the year (**69.0%**), with **24.5%** living in temporary housing and **5.3%** living in unstable housing, including in shelters and on the street.

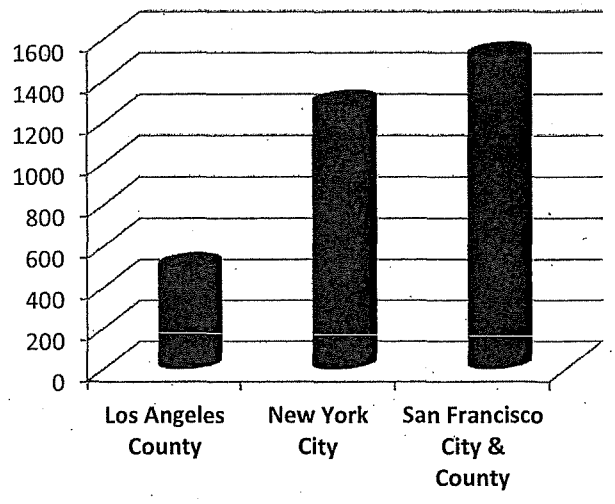
Insurance Coverage: The advent of health care reform through the Affordable Care Act (ACA) has resulted in significant, positive change in regard to the number and proportion of low-income persons with HIV in our region who benefit from affordable and more accessible health insurance coverage. According to the UCLA Center for Health Policy Research, the number of uninsured Californians had fallen by as much as **40%** as of February 2016 as a result of ACA implementation.[10] Nevertheless, significant insurance

gaps continue to remain in our region. Analysis of local ARIES data revealed that **30.7%** of all persons enrolled in Ryan White Part A services in the three-county regions during the 2016-2017 fiscal year were uninsured at some point during the year, including persons without Medicaid or Medicare.

Additionally, significant **disparities** exist in regard to type of health insurance coverage among newly diagnosed persons with HIV. While the percentage of persons in San Francisco who had insurance at the time of HIV diagnosis was relatively comparable across ethnic groups (**67%** of whites: **66%** of African Americans; **60%** of Latinos; and **59%** of other ethnic groups) the **type** of insurance varied greatly among populations. For example, while **46.9%** of whites had private insurance at the time of HIV diagnosis, only **16.0%** of African Americans and **35.6%** of Latinos had private insurance. Conversely, while **11.1%** of whites and **13.0%** of Latinos had Medicaid coverage at the time of diagnosis, fully **34.4%** of African Americans were covered by Medicaid at the time of initial HIV diagnosis. Even more ominous is the fact that nearly **35%** of whites and African Americans and **40%** of Latinos and other populations were **uninsured** at the time of diagnosis, despite extensive regional efforts to enroll low-income individuals in one of the region's many medical insurance programs tailored to these populations.

The issue of persons **losing their private disability insurance** is growing in importance as the population of PLWH who are 50 years or older increases and are more likely to rely on private disability insurance than their younger counterparts. In October of 2014, the San Francisco Board of Supervisors, Budget and Legislative Analyst Office released a Policy Analysis Report on PLWH who age off Long Term Disability Insurance. The report reviewed data from several sources to estimate the number of PLWH who have private disability insurance and will reach retirement age and Social Security eligibility in the next 15 years. The report found that over **1,200** PLWH over 50 years old rely on private disability insurance, which terminates at age 65. The overall effect of the drop in income that will occur as people lose their private disability insurance is difficult to predict conclusively. However, evidence does suggest that for many PLWH, the lost income will make it impossible to afford San Francisco's current median rent.

Figure 6. Persons Living with HIV Per 100,000 Population - Selected Metropolitan Areas



<u>Burden of HIV in the Service Area:</u> It is important to note that the City of San Francisco continues to have the **largest per capita concentration of persons living with HIV of any metropolitan region in the United States.** As noted above, as of the end of 2016, a total of **13,216** San Franciscans were living with diagnosed HIV, representing **84.2%** of all persons living with HIV in the EMA **This means that 1 in every 66 San Francisco residents is now living with HIV disease - an**

astonishing concentration of HIV infection in a city with a population of 870,000 residents. The incidence of **1,517.5** persons living with HIV per 100,000 in San Francisco County is **over three times** that of Los Angeles County (**498.1** per 100,000) and **35% higher** than New York City (**1,285,5** per 100,000) (see **Figure 6**).[11]

c. <u>New HIV Infections:</u>

i. <u>Trends in New HIV Infections:</u> **As a result of the SF EMA's assertive 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, while the disparities gap for new infections among African American and Latino men is beginning to close.** The total of **343** new cases of HIV infection diagnosed in the SF EMA in calendar year 2016 is the fewest number of regional new infections in the history of the HIV epidemic, while the **223** new HIV cases diagnosed in San Francisco represents a **16% reduction** over the last year alone, and a **49% reduction** over the past four years, from 2012 to 2016. Between 2006 and 2016, the number of newly identified HIV infections among white men in the SF EMA declined by **129.8%**, from **278** to **121** new cases, while the number of newly identified cases among African American men declined by **70.5%**, from **75** in 2006 to **44** in 2016. While new HIV cases among Latino men remained relatively consistent across the EMA, the rate of new HIV diagnoses among Latino men in SF dropped from **85** per 100,000 in 2015 to **77** per 100,000 in 2016, a reduction of nearly **10%** in one year. Meanwhile, new HIV diagnoses among women continue to drop dramatically, most notably with a decline in new HIV diagnoses among African American women from **47** new diagnoses in 2006 to **10** new diagnoses in 2016. The rate of new HIV infections per 100,000 among women in San Francisco is **4** for white women, **6** for Latina women, and **9** for African American women.

These successes stem from a variety of factors, including ongoing Ryan White funding; San Francisco's longstanding model of comprehensive and integrated HIV outreach, testing, linkage, and care services; our region's strong commitment to supporting comprehensive HIV services; California's early embrace of the Affordable Care Act (ACA); and the efforts of the SF **Getting to Zero Consortium**, (www.gettingtozerosf) a multi-sector initiative involving community-based organizations, providers, researchers, health department and government officials, consumers, and activists, which has been working since 2014 toward the goals of zero new HIV infections, zero HIV-associated deaths, and zero stigma and discrimination. The local Getting to Zero Consortium has allowed San Francisco to serve in some ways a **national laboratory** for testing whether focused HIV initiative across the care continuum can eventually reduce and eliminate HIV as a public health threat. Additional successes of these efforts include the following:

- Overall, 93% of people living with HIV in San Francisco are **aware of their infection.**
- The proportion of **late diagnoses** (progressing to AIDS within 3 months of HIV diagnosis) declined from **21%** in 2012 to **16%** in 2015. Nationally the proportion of late testers is **22%.**

- Only **6.4%** of people living with HIV are **persons who inject drugs (PWID)** and only **6.4%** of new diagnoses were among PWID due to the success of long-standing syringe access programs in San Francisco.

- **Linkage to care** within 1 month of HIV diagnosis has increased significantly among newly diagnosed PLWH; in 2016, **84%** of newly identified PLWH were linked to care within 1 month of diagnosis as compared to **77%** in 2012.

- **Viral suppression** within 1 year of diagnosis has also increased among newly diagnosed people, growing from **68%** in 2012 to **77%** in 2015.

- **Time to ART (Antiretroviral Therapy) initiation** after HIV diagnosis has improved from a median time (when 50% initiated ART) of **8** months in 2009 to **1** month in 2015.

- **Time to viral suppression** after HIV diagnosis has improved, with median time to viral suppression increasing from **11** months in 2009 to **3** months in 2015.

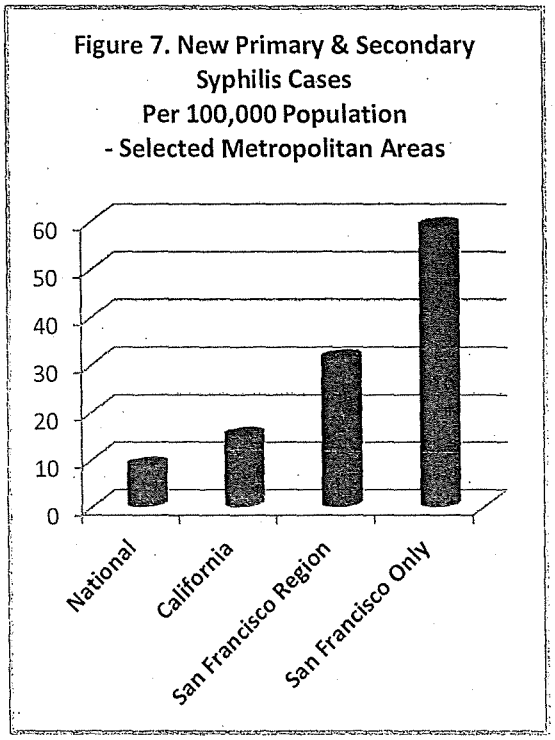
ii. Increasing Need for HIV Services: While the successes of the San Francisco approach to HIV prevention, identification, and care are both significant and heartening, it is critical to note that a large share of the model's success is attributable to the **significant federal resources** that have been made available to support both prevention and care efforts, including efforts to more rapidly identify and link persons with HIV to care and to retain them in care and on medication regimens on a long-term basis. This includes expanded Medicaid reimbursement through ACA and the continuing support for HIV care through Ryan White Part A and other programs, which enable persons with HIV to achieve long-term viral suppression and reduce the rate of new HIV infections in our region. At the same time, the total number of persons living with HIV in the EMA continues to expand, while the increasing number of persons 50 and older with HIV puts increasing demands on the system to meet more complex HIV-related aging needs. To sustain the success of the San Francisco approach to eliminating HIV, and to allow the region to continue to serve as a national laboratory for HIV case reductions, these federal resources will continue to be of the utmost importance. Any reduction in federal support for health, HIV, and related services has the potentially to rapidly undo the progress we have made, and to bring us back to a time when we are no longer able to share news or reduced caseloads, but to once again coping with a public health emergency in which funds are inadequate to stop a new surge of HIV infection and HIV-related morbidity and mortality.

2. Co-Occurring Conditions

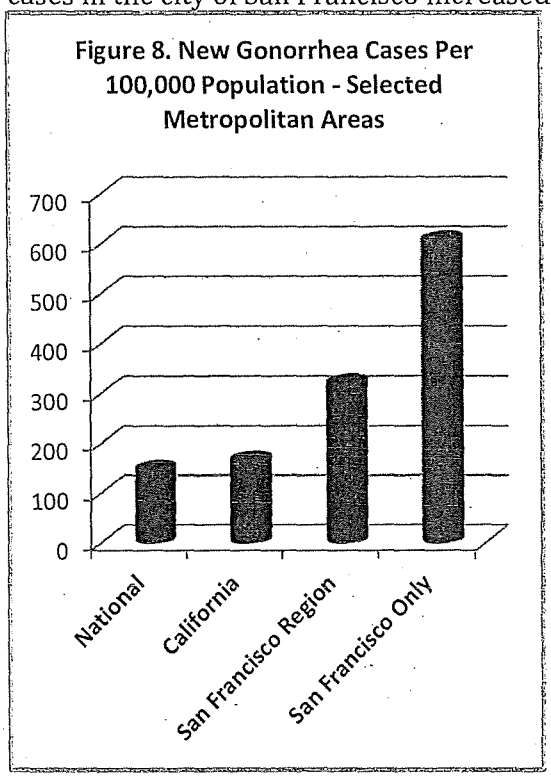
Please see **Co-Occurring Conditions Table** in **Attachment 4.**

Sexually Transmitted Infections (STIs): The growing crisis of sexually transmitted infections is of significant concern for the future of the HIV epidemic in our region. In terms of **syphilis**, for example, the SF Jurisdiction continues to confront a major epidemic that has been escalating for the past half-decade, rising more than **500%** since 2000. In calendar year 2016, a total of **594** new primary and secondary syphilis cases were diagnosed in the

three-county San Francisco region, representing a **159%** increase over the 229 cases reported 9 years earlier in 2007.[12] The combined SF jurisdiction-wide syphilis rate of **31.3** per 100,000 in 2016 is over **twice** the California statewide rate of **15.0** per 100,000. Within the City of San Francisco alone, a total of **514** new syphilis cases were reported in 2016 for an extremely high incidence rate of **59.0** cases per 100,000, a rate **four times higher** than the statewide rate and **nearly seven times higher** than the national syphilis rate of **8.7** cases per 100,000 in 2015 (see **Figure 7**). San Francisco County has by far the largest syphilis infection rate of any county in California, **50% higher** than rate of the second highest county, Fresno County (**39.4** per 100,000) and nearly **four times** that of Los Angeles County (**17.8** per 100,000).

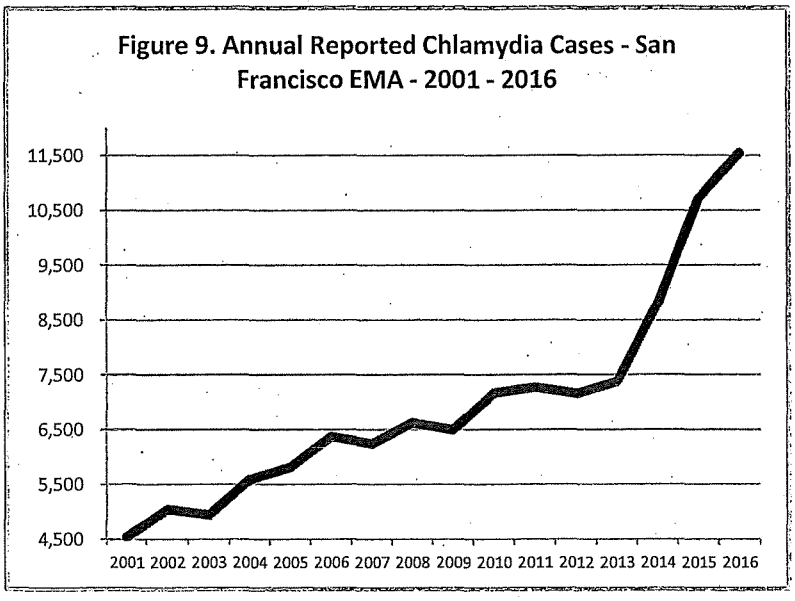


The region is also experiencing a significant **gonorrhea** epidemic. A total of **6,054** new gonorrhea cases were identified in the San Francisco Jurisdiction in 2016, for a Jurisdiction-wide incidence of **319.3** cases per 100,000 – a rate **nearly double** the 2016 California rate of **164.3** cases per 100,000 (see **Figure 8**).[13] The number of new gonorrhea cases in the city of San Francisco increased by **174%** between 2010 and 2016 alone, growing from **1,927** reported cases in 2010 to **5,280** cases in 2016. The City of San Francisco's 2016 gonorrhea incidence of **606.3** per 100,000 is nearly **five times** the national rate of **145.8** cases per 100,000 and nearly **four times higher** than the State of California as a whole (**164.3**). This is again by far the highest rate of any county in California, with the next highest county – Lake County – having a case rate of **311.7** per 100,000, roughly **half** the gonorrhea rate in SF.

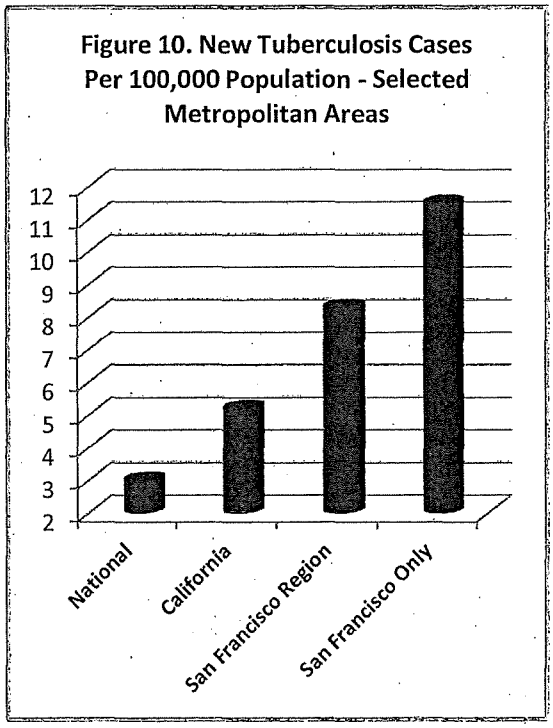


The region's **Chlamydia** epidemic also continues to increase, with rates rising precipitously. A total of **11,539** new cases of Chlamydia were diagnosed in the three-county region Jurisdiction in 2016, representing an **84.2%** increase over the **5,816** cases diagnosed in 2005, a nearly **100% increase** since 2001 (see **Figure 9**).[14] The 2016 Jurisdiction-wide Chlamydia incidence stood at **608.5** per 100,000, while the rate for the City

of San Francisco was **939.7** cases per 100,000. By comparison, the 2016 incidence for California was **504.4** cases per 100,000, while the national rate was **497.3.**



The cost of treating STIs adds significantly to the cost of HIV care in the San Francisco Jurisdiction. According to a study which estimated the direct medical cost of STIs among American youth, the total annual cost of the 9 million new STI cases occurring among 15-24-year-olds totaled $6.5 billion in the US, at a per capita cost of $7,220 per person. Lissovoy and colleagues estimated US national medical expenditures for congenital syphilis for the first year following diagnosis at between $6.2 million and $47 million for 4,400 cases, or as high as $10,682 per case.[23] A study published in the American Journal of Public Health estimated that a total of 545 new cases of HIV infection among African Americans could be attributed to the facilitative effects of infectious syphilis, at a cost of about $113 million, or a per capita cost of $20,730.[24] Such studies suggest that the total cost of treating new STIs in our region may be as high as **$12.4 million** per year, including an estimated **$1.9 million** to treat STIs among persons with HIV and another **$7.5 million** in potential annual costs resulting from the need to treat persons infected with HIV as a result of transmission facilitated through other STIs.



Tuberculosis (TB): Tuberculosis is an additional critical health factor linked to HIV, particularly in terms of its effects on recent immigrants and the homeless. The magnitude of the local TB crisis is comparable to syphilis and gonorrhea, with a combined total of **158** new cases of TB diagnosed in the three-county region in 2019, representing an area-wide incidence of **8.3** cases per 100,000. In San Francisco, the incidence is even higher, at **11.5** cases per 100,000. San Francisco County's 2016 TB rate ranked **second** out of California's 58 counties, while San Mateo County ranked **fifth.** San Francisco's TB incidence rate is **more than double** the statewide rate of **5.2** cases per 100,000 and **nearly four times higher** than the national rate of **3.0** cases per 100,000

(see **Figure 10**).[27] Treatment for multi-drug resistant tuberculosis is particularly expensive, with one study indicating that the cost averaged $89,594 per person for those who survived, and as much as $717,555 for patients who died.

Hepatitis C: The hepatitis C virus (HCV) is the nation's most common blood-borne infection, a major cause of liver cancer, and the leading cause of liver transplants in the US. In the United States as a whole, HCV prevalence is approximately **five times greater** than HIV prevalence, and approximately **25%** of HIV-positive individuals are co-infected with HCV infection.[15] Community-based antibody screening among high–risk populations in San Francisco has yielded a HCV antibody positivity rate of **5.4%,** while HCV antibody screening in San Francisco jails has yielded an antibody positivity rate of **10%.** Surveillance data also indicates tremendous disparities in HCV prevalence in San Francisco. While African Americans represent **6.6%** of San Francisco's general population, they account for at least **one-third** of San Francisco's HCV cases and **23.5%** of the population of people who are co-infected with HIV and HCV. The San Francisco Department of Public Health also estimates that as many as **90%** of all chronic injection drug users over the age of 30 may already be infected with hepatitis C. Despite the tremendous disease burden of HCV, there has historically been a dearth of federal, state, and local funding for HCV surveillance, prevention, and care activities.

At the same time, however, significant advancements have been made in hepatitis C treatment over the past several years, with the introduction of new, albeit expensive treatments that have **successful cure rates of over 90%** in persons living with HCV. While these treatments are extremely costly, the San Francisco region has taken the initiative to harness these treatments in order to attempt to **end hepatitis C among persons living with HIV by the end of 2019** - a direct objective contained in this document's Action Plan. The **End Hep C SF** initiative is built on three distinct pillars: 1) Citywide community-based HCV testing for highly impacted populations paired with augmented HCV surveillance infrastructure to track the HCV epidemic and progress towards elimination; 2) Linkage to care and treatment access for all people living with HCV; and 3) Prevention of new HCV infections and reinfection in those cured of HCV. The initiative will be specifically applied to persons living with HIV in concert with the San Francisco Department of Public Health and local HIV clinics and care sites. The City is excited by the prospect of heading a model program to dramatically extend HIV lifespan and health by striving to eliminate Hep C among persons with HIV over the next three years.

Additional Co-Factors: The high prevalence of **mental illness** and **mental health issues** in the San Francisco EMA complicates the task of delivering effective services and retaining persons with HIV in care. The San Francisco Department of Public Health, Behavioral Health Section's most recent report noted that **12,000** seriously emotionally disturbed children and youth and **32,000** seriously mentally ill adults live in San Francisco, and that up to **37%** of San Francisco's homeless population suffers from some form of mental illness.[16] In part because of the Golden Gate Bridge, San Francisco also has one of the nation's highest rates of both adult and teen suicide completion, and the rate of suicide per capita in San Francisco is **twice as high** as the city's homicide rate.[17] When coupled with the second highest incidence of homelessness in the US, these statistics reflect the high incidence of multiply diagnosed clients in the EMA. Among persons with severe mental illness, the research literature documents a broad range of HIV seroprevalence rates, from **4%** to as high as **23%.**[18] Mental illness, depression, and dementia are also

increasingly common among HIV-diagnosed populations, with **31%** of HIV clients at one San Francisco clinic having concomitant mental illness, and **80%** of clients at another clinic having a major psychiatric condition. One recent study found a **37%** prevalence of depression in HIV-infected men in San Francisco.[19]

The problem of **substance use** also plays a central role in the dynamics of the HIV epidemic, creating challenges for providers while presenting a critical barrier to care for HIV-infected individuals. The EMA is in the throes of a major substance abuse epidemic which is fueling the spread not only of HIV but of co-morbidities such as sexually transmitted infections, hepatitis C, mental illness, and homelessness – conditions that complicate the care system's ability to bring and retain PLWH in care. According to the most recent report by the California Office of Statewide Health Planning and Development, an average of **8.5** hospitalizations per 10,000 occurred in San Francisco, well above the average statewide rate of **6.6** per 10,000.[20] At the same time, the rate for drug-induced deaths in San Francisco stood at **24.8** per 100,000, more than double the statewide rate of **10.8** per 100,000.[21] Drugs and drug-related poisonings are also the **leading** cause of injury deaths among San Franciscans, **with nearly three San Franciscans dying each week of a drug-related overdose or poisoning**.[22] In terms of HIV, the most alarming current threat involves the local epidemic of **methamphetamine (speed).** Health experts currently estimate that up to **40%** of gay men in San Francisco have tried methamphetamine,[23] and recreational crystal use has been linked to **30%** of San Francisco's new HIV infections in recent years.[24]

3. Complexities of Providing Care

a. Reduction in Part A Formula Funding:

i. Impact: For the second consecutive year, the San Francisco EMA experienced a slight reduction in Part A formula funding, with formula funds decreasing by **$262,594** from FY 2015 to FY 2016 and **$63,511**, from FY 2015 to FY 2016. However, these reductions were offset each year by increases in the region's supplemental funding awards.

ii. Response: No service reductions or cost cutting measures were needed in the SF EMA as a result of formula funding reductions, which can be attributed in large part to the region's success in reducing the rate of new HIV infections.

b. Poverty and Health Care Coverage Table: (See **Figure 11** below)

Figure 11. Poverty and Health Care Coverage Table

Demographic Category	Unduplicated Clients Enrolled in Ryan White Services in SF EMA 3/1/16 - 2/28/17	
Federal Poverty Level (FPL)		
0 - 100% of FPL	3,252	62.4%
101% - 200% of FPL	1,450	27.8%
201 - 300% of FPL	327	6.3%
301% of FPL and Higher	140	2.7%

Figure 11. Poverty and Health Care Coverage Table		
Demographic Category	**Unduplicated Clients Enrolled in Ryan White Services in SF EMA 3/1/16 - 2/28/17**	
Unknown	39	0.8%
Current Living Situation		
Stable	3,591	69.0%
Temporary	1,275	24.5%
Unstable	275	5.3%
Unknown	67	1.3%
Insurance Status		
Private	430	8.3%
Medicare	1,599	30.7%
Medicaid	3,503	67.3%
No Insurance	1,601	30.7%
Other	2,553	49.0%
Unknown	288	5.5%
▪ Basic Threshold for Ryan White Eligibility in SF EMA: **400% or Less** of Current FPL		

c. <u>Factors Limiting Access to Health Care / Service Gaps</u>

<u>Factors Limiting Health Care Access</u>: Despite regional successes in reducing the number of persons who are not covered by insurance, some barriers to ongoing, universal health care coverage continue to exist. Many homeless and highly impoverished persons with HIV entering care are either not currently covered by insurance or have had their coverage lapse in the recent past, a factor that accounts for the relatively large percentages of clients in the table above who have been listed as having "no insurance" at some point during the previous Ryan White fiscal year. The vast majority of these individuals are rapidly enrolled in Medicaid or other insurance programs upon presenting for care at HIV service sites. The same issue applies to incarcerated persons, who frequently lose their coverage while in prison or jail, and who must be re-enrolled and re-qualified following their release. In some cases, individuals who are enrolled in the **San Francisco Health Plan** are listed as having no insurance because the Plan is not technically a health insurance plan. For the most part, however, SF EMA HIV providers have become highly adept at both enrolling and re-certifying persons with HIV in appropriate insurance and benefits plans, and ensure that the vast majority of persons living with HIV in our region have access to high-quality care and support services on an ongoing basis.

In terms of **service gaps**, the chart below compares the population of PLWH enrolled in the San Francisco EMA Ryan White system of care for FY 2016-2017 with the EMA's combined PLWH population as of 12/31/16 (see **Figure 12**)

Figure 12. Comparison of San Francisco EMA Ryan White Clients with Overall PLWH Population

Demographic Group / Exposure Category	Total Unduplicated Clients Enrolled in Ryan White Services - 3/1/16 - 2/28/17		Combined SF EMA PLWH Population as of 12/31/16		Population Variances
Race/Ethnicity					
African American	1,022	19.6%	1,989	12.7%	**+ 6.9%**
Latino / Hispanic	1,432	27.5%	3,466	22.1%	**+ 5.4%**
Asian / Pacific Islander	304	5.8%	1,056	6.7%	**- 0.9%**
White (not Hispanic)	2,081	40.0%	8,617	54.9%	**- 14.9%**
Other / Multiethnic / Unknown	369	7.1%	563	3.6%	**+ 3.5%**
	5,208	**100%**	**15,691**	**100%**	
Gender					
Female	606	11.6%	1,044	6.7%	**+ 4.9%**
Male	4,393	84.4%	14,252	90.8%	**- 6.4%**
Transgender	209	4.0%	395	2.5%	**+ 1.5%**
	5,208	**100%**	**15,691**	**100%**	
Age					
0 - 24 Years	84	1.6%	174	1.1%	**+ 0.5%**
25 - 29 Years	221	4.2%	550	3.5%	**+ 0.7%**
30 - 49 Years	1,966	37.7%	5,853	37.3%	**+ 0.4%**
50 - 64 Years	2,436	46.8%	7,405	47.2%	**- 0.4%**
65 Years and Above	501	9.6%	1,709	10.9%	**- 1.3%**
	5,208	**100%**	**15,691**	**100%**	
Transmission Categories					
MSM	2,802	53.8%	11,323	72.2%	**- 18.4%**
Injection Drug Users	536	10.3%	1,010	6.4%	**+ 3.9%**
MSM Who Inject Drugs	474	9.1%	2,075	13.2%	**- 4.1%**
Non-IDU Heterosexuals	370	7.1%	1,027	6.5%	**+ 0.6%**
Other	120	2.3%	64	0.4%	**+ 1.9%**
Unreported / Unknown	906	17.4%	192	1.2%	**+ 16.2%**
TOTAL	**5,208**	**100%**	**15,691**	**100%**	

Compared to their proportion of HIV cases, **women, persons of color, heterosexuals, injection drug users,** and **transgender people** are **over-represented** in the local Ryan White Part A-funded system, Meanwhile, **whites, men,** and **MSM** are significantly **underrepresented** due largely to higher average incomes and higher rates of private insurance which reduce their need to rely on Ryan White-funded care. For example, while women make up only **6.7%** of all PLWH in the EMA, they comprise **11.7%** of all Ryan White Part A clients as of February 28, 2017. Meanwhile, while whites make up **54.9%** of all PLWH in the EMA, they comprise only **40.0%** of Ryan White Part A clients as of the same date. Ryan White clinics provide primary medical care to a population that is disproportionately made up of persons of color, women, persons with low incomes, the homeless, heterosexuals, and injection drug users. Additionally, local Part D programs

primarily serve young people and women, while Part C programs such as those operated by the San Francisco Clinic Consortium serve the full spectrum of clients, including the homeless, persons of color, women, and gay/bisexual men. Fully **19.6%** of Ryan White Part A clients in the San Francisco EMA are African American (n=**1,022**) despite the fact that they comprise **12.7%** of all persons with HIV in the EMA. At the same time, San Francisco's seven **Centers of Excellence** which focus on underserved and hard-to-reach populations serve a population that is **30.6%** African American.[25] Women, representing **6.6%** of the total PLWH population, make up **21.7%** of all Centers of Excellence clients. Transgender people make up **3.5%** of persons served through the Ryan White system and **5.4%** of persons served through Centers of Excellence, while making up **2.4%** of all persons living with HIV in the EMA. **All of these statistics highlight the progress the San Francisco EMA has made in reaching and bringing into consistent care the most impoverished and highly underserved HIV-infected residents of the region.** In fact, between FY 2014 and FY 2015 alone, the number of clients in the local Ryan White system increased by **14.1%**, from **6.503** total clients served in FY 2014 to **7,420** total clients served in FY 2015.

In addition to direct needs assessment activities, a primary methodology for identifying service gaps in our region involves **analyzing disparities** in relation to HIV prevention and care activities. Identified disparities across ethnic, gender, age, and transmission categories reveal the ways in which our system, despite continual progress, is still falling short of equitably meeting the needs of all persons at risk for and living with HIV in our region. Identified disparities also indicate where our region needs to focus its energy and resources to meet our Getting to Zero goals. In terms of disparities along the HIV Care Continuum, the chart below indicates populations that achieve lower percentages of success in terms of HIV prevalence, rates of new infection, ART initiation, and viral suppression (see **Figure 13**). For purposes of the table, a "disparity" is defined as occurring when a population is disproportionately affected by an issue, either when compared between specific sub-populations (such as African Americans compared to whites) or when compared to the total population. These disparities are addressed by specific objectives and action steps contained in our action plan, particularly in regard to Objectives #1.2 and 2.2.

Figure 13. Populations Affected by Disparities in Relation to the HIV Care Continuum

Indicator	Populations with Disparities
HIV Prevalence Relative to Size of Sub-Populations	▪ Men Who Have Sex with Men (MSM) ▪ Transfemales ▪ African American MSM ▪ African American Transfemales ▪ 50 years and older
Estimated Rate of New Infections per 100,000	▪ MSM ▪ Latinos ▪ Age Group 13-29

Less Likely to Achieve Antiretroviral therapy (ART) Initiation Compared to Overall Estimated Regional ART Levels	▪ Females ▪ African American ▪ Asian/Pacific Islander (API) ▪ Native American ▪ Multi-racial ▪ Heterosexual ▪ Homeless ▪ Public or No insurance at diagnosis
Less Likely to Achieve Viral Suppression Compared to Overall Estimated Regional Viral Suppression Rates	▪ Female ▪ Transfemale ▪ African Americans ▪ Latino ▪ Current Age Under 40 ▪ People Who Inject Drugs (PWID) MSM-PWID

To address service gaps, the San Francisco HIV Community Planning Council and the SF Department of Public Health work together to ensure that Ryan White Part A funds are coordinated across all applicable funding streams in the region and that they address identified service gaps at all levels of client care and support. The Planning Council reviews annual service category summaries that include a detailed listing of all Ryan White and non-Ryan White funding sources for each category, including sources such as ADAP, Medicaid and Medicare support, public entitlement programs, private insurance and HMO support, Veterans Administration programs, City and County funds, HOPWA and SAMHSA grants, and State mental health funds. The Grantee also ensures that services are coordinated to maximize accessibility of services, while seeking every possible alternate source of funding apart from Part A to support HIV care.

The San Francisco EMA is also dedicated to ensuring the integration and coordination of **all** sources of Ryan White funding in the region. The Planning Council prioritizes the use of Ryan White funds for services that are not adequately funded through other reimbursement streams to ensure that Part A funds are the funding source of last resort. During each year's priority setting and allocation process, the Grantee produces detailed fact sheets on each service category that include a listing of **all** other funding streams available for that category, including Part B, C, D, and F programs, ADAP, and MAI funding. The Planning Council also assists in the planning for Part B-funded services. The Planning Council works with other local planning groups such as the HIV Prevention Planning Council and Long-**Term** Care Coordinating Council to coordinate services and eliminate duplication.

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**[26]

1. EIIHA Plan

a. Primary Activities to be Undertaken:

The FY 2018 EIIHA Plan will encompass **three** broad activity areas which mirror those of the three succeeding EIIHA plans. The **first** area involves continuing to identify individuals who are unaware of their HIV status. Most MSM will be provided with high-quality rapid testing and acute RNA pooled screening. San Francisco is using rapid 4th generation combination antibody / antigen (Ab/Ag) tests at sites that do not currently have access to pooled RNA testing. The 4th generation rapid testing identifies not only HIV antibodies but also HIV-1 p24 antigens, which allows for early identification and rapid treatment of acute HIV infection. All other existing rapid HIV screening technologies have window periods exceeding the acute infection period, which may result in false negative tests in acutely-infected patients, and in turn lead not only to missed HIV diagnoses but to lost opportunities to intervene with treatment and counseling at the time when an individual is at greatest risk to pass their HIV infection on to others. Additionally, the 4th generation HIV Ab/Ag combination tests provide result in 20 minutes.

The **second** key activity area involves ensuring that HIV-positive individuals are successfully linked to essential medical and social services based on individual need. Specific activities to be undertaken through the Plan will be tailored to meet the needs of its three identified target population groups, with a particular emphasis on continuing to implement the city-wide **Linkage Integration Navigation Comprehensive Services (LINCS) program** for both newly identified and as re-linked individuals who have been out of care. Created in 2015, LINCS is a highly effective program designed to increase the number of HIV-infected individuals who are effectively linked to and anchored in care. The LINCS Team provides a comprehensive range of services based on individual client needs and circumstances, incorporating linkage to HIV medical care, social services, partner services, and retention services under a single umbrella. LINCS employs an integrated team of **15** full-time staff. **Eight** staff provide HIV and syphilis partner services and linkage to care to newly diagnosed patients, and **7** staff provide HIV care navigation to patients who are identified as out of care by healthcare providers or through HIV surveillance data. Of note, 6 of these navigation staff are short-term grant-funded through the MAC AIDS Foundation and CDC's Project PrIDE (PrEP, Implementation, Data2Care, Evaluation). LINCS Team members are directly paired with newly identified HIV-positive individuals and remain paired in a supportive relationship for up to **three months** following initial HIV diagnosis. The ensures that: 1) linkage to care is made **within 30 days** for **everyone**

testing positive in San Francisco; and 2) **all** newly-diagnosed individuals are offered comprehensive and immediate linkage and partner services.

In 2015, through the LINCS program, **84%** of newly diagnosed patients were linked to care within 1 month and **75% were virally suppressed within 12 months of diagnosis.** By comparison, among all people living with HIV in SF, the overall viral suppression rate is **72%.** By expanding LINCS navigation capacity, we are hoping to improve this rate. In the first 9 months of expanding LINCS navigation capacity, the program received a total of **321** referrals; located and enrolled **120** patients into navigation; re-linked **108 (90%)** of these patients to care; and increased viral suppression among this population from **11%** to **50%. One-third** of clients re-linked to care are **homeless** and nearly **half** are substance-using. These data suggest that the LINCS navigation efforts are highly effective and should be sustained beyond the grant-funded period in order to sustain improvements in viral suppression city-wide.

A **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. 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; and 4) public health detailing. San Francisco has vigorously embraced PrEP as an effective approach to reducing new infections among high-risk individuals in the EMA. San Francisco 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.[27] The following is an overview of San Francisco's PrEP strategy:

1) Community, Clinic, and Pharmacy-Based PrEP Programs:

- By early 2017, ensure that **7** community-based PrEP community engagement and navigation programs in place, four of which will focus on particular populations with disparities in PrEP awareness, access, and uptake: African American MSM, Latino MSM, young MSM, and trans women. (Three programs are supported by funds prioritized by Supervisor Campos; four are supported by SF city funds raised by the G2Z consortium supplemented by funding from the CDC PRIDE grant).
- Expand the well-established San Francisco City Clinic PrEP delivery program including, exploring ways to use rectal STI data to craft and pilot a "data to PrEP" model, modeled after "data to care" efforts.
- Ensure training by the San Francisco Health Network to prescribe and administer PrEP at the Network's **14** neighborhood clinics and through the Ward 86 HIV Clinic at Zuckerberg San Francisco General (ZSFG) hospital. This includes a novel PrEP tele-medicine program designed to promote medication adherence and regular follow-up HIV/STI testing using a panel management approach.
- Test an innovative pharmacy-based PrEP access model that does **not require a doctor's visit,** providing Truvada to youth who are ineligible for insurance or who are on their parents' insurance and are concerned about disclosure.

2) Training of HIV/HCV Test Counselors to Provide a Gateway to PrEP:

- Ensure that San Francisco's model 4-day HIV/HCV certification program now includes a PrEP module. The goal of this module is to develop skills needed to help clients determine if PrEP is right for them and if so, how to access it. Among other outcomes, this training has already greatly supported consistent messaging to high-risk groups to provide assurance that PrEP is safe and accessible.

3) Social Marketing:

- Continue to implement the SFDPH "Our Sexual Revolution" campaign designed to raise awareness of PrEP among MSM of color and transwomen. (http://oursexualrevolution.org/).

4) Public Health Detailing:

- Deploy PrEP experts to conduct public health detailing with doctors throughout the City to support clinicians to expand their competency in prescribing PrEP and conducting appropriate assessment and follow-up.

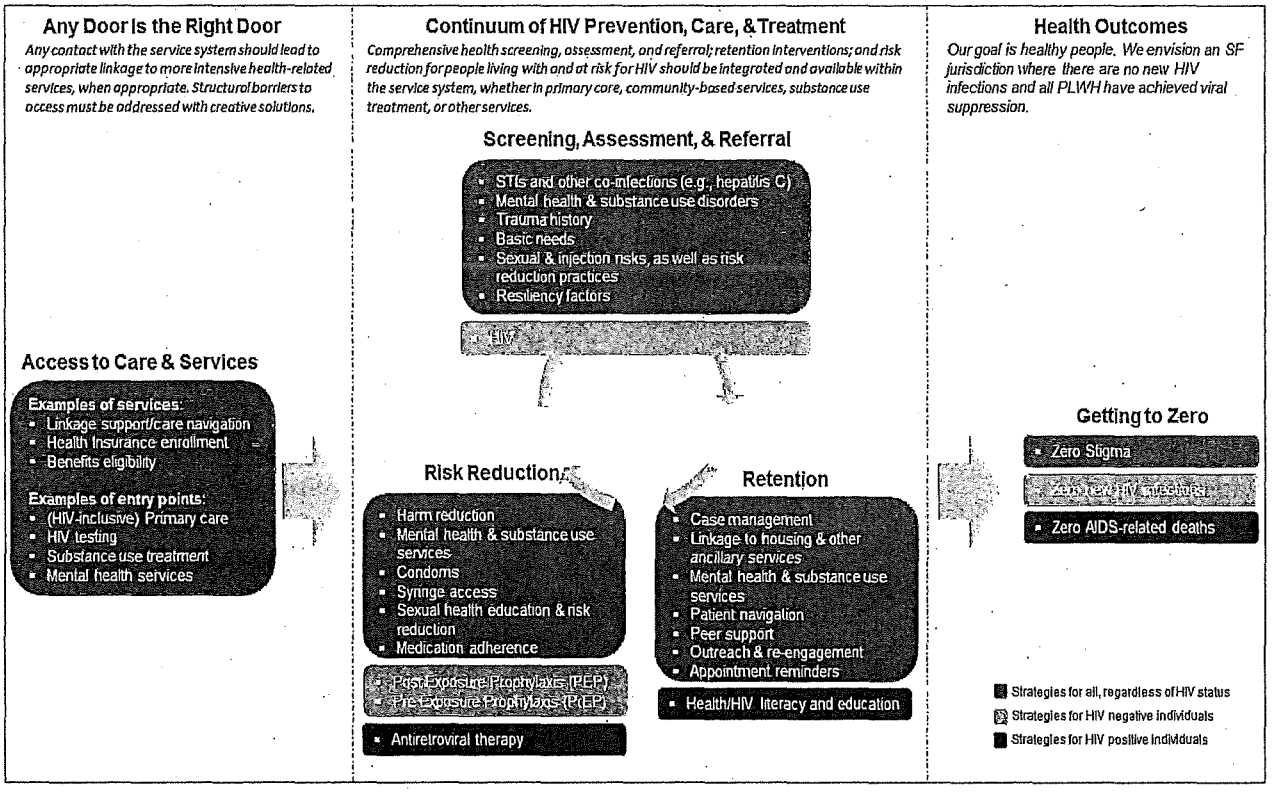
The SF EMA aims to achieve an HIV prevention and care continuum in which no one is at risk for HIV, and everyone who is living with HIV knows their status, is linked to and retained in care, and is virally suppressed (see **Figure 14**). The EIIHA Plan contributes to improving health outcomes in the 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. DPH 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 **linkage and retention** rates through continued implementation of the LINCS program as well as expanded case management services
- Increasing **viral suppression** as a direct result of improvements along the rest of the continuum

b. <u>Major Collaborations:</u>

HIV Health Services works in close partnership with the three Branches in the Population Health Division - Community Health Equity & Promotion (CHEP), Disease Prevention & Control (DPC), and Applied Research, Community Health Epidemiology & Surveillance (ARCHES) Branches to plan services, design interventions, and share data and emerging findings. CHEP oversees community-based prevention and testing services; DPC oversees the LINCS program and operates City Clinic (the municipal STD clinic which offers HIV testing, PrEP, and HIV early care); and ARCHES maintains the SF spectrum of

Figure 14: San Francisco Jurisdiction Holistic Health Framework for HIV Prevention and Care



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 to 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 also aims to ensure non-duplication and non-supplantation of Ryan White Program funding. The collaboration is augmented by strong working relationships involving virtually all providers of HIV-specific prevention and care services in the EMA, as well as agencies serving high-prevalence populations at risk for HIV infection.

The EIIHA Plan is supported by two additional key collaborators – 1) the **HIV Community Planning Council (HCPC),** our region's newly 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 (G2Z) 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 goals, 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 G2Z coalition work with DPH to establish and implement priorities to improve outcomes along the HIV prevention, care, and treatment continuum.

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 C, D, and F play an active role on the Planning Council to ensure integration and coordination of EIIHA activities with other Ryan White-funded services.

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

The FY 2018 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 G2Z is successful, the need for an early intervention plan should greatly diminish, because new infections will be virtually eliminated.

Specific anticipated outcomes of the local EIIHA strategy are codified as objectives in the new 2017-2021 Integrated HIV Prevention and Care Plan developed for the San Francisco region. Each objective corresponds to a specific objective of the

National HIV/AIDS Strategy, and represent aggressive approaches to achieving rapid enhancements along the entire HIV care continuum, including the following:

- **Objective # 1.1:** By December 31, 2021, increase the percentage of people living with HIV who know their serostatus to at least **96%**;
- **Objective # 1.2:** By December 31, 2021, reduce the number of annual new HIV diagnoses by at least **50%**;
- **Objective # 1.3:** By December 31, 2021, increase the utilization of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) among high-risk HIV-negative persons by at least **50%**; and
- **Objective # 2.1:** By December 31, 2021, increase the percentage of annual newly diagnosed persons linked to HIV medical care within one month of HIV diagnosis to at least **90%.**

The FY 2018 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 group 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.

2. Legal Barriers and Solutions

Major current HIV-specific legal issues and accomplishments in California include the following:

- California law requires that every patient who has blood drawn at a primary care clinic, and who has consented to the test, be offered an HIV test that is consistent with the United States Preventive Services Task Force recommendations for screening for HIV infection. A new bill passed in September 2016 created a pilot project, administered by the State Department of Public Health, to assess and make recommendations regarding the effectiveness of the routine offering of an HIV test in the emergency department of a hospital.
- On October 6, 2017, Governor Brown signed into law landmark legislation to reform outdated laws that had unfairly criminalized and stigmatized people living with HIV. Senate Bill (SB) 239 updates California criminal law to approach transmission of HIV in the same way as transmission of other serious communicable diseases. It also brings California statutes up to date with the current understanding of HIV prevention, treatment and transmission. The bill fulfills a key goal of the National HIV/AIDS Strategy and is consistent with guidance from the U.S. Department of Justice and with California's "Getting to Zero" HIV transmission reduction strategy.

- At the current time, local health jurisdictions in California do not have access to data on prescribed PrEP medications for persons who are not infected with HIV. This makes it difficult to ascertain both the scope of PrEP treatment in our region, and the specific demographics of PrEP populations, which would in turn allow us to identify and address PrEP utilization disparities. The San Francisco EMA is supporting efforts to give access to PrEP prescription data for persons not currently infected with HIV.

3. Description of Target Populations

a. Why Target Populations Were Chosen:

To define and focus EIIHA activities, the following **three** populations will continue to serve as the key target groups for the FY 2018 San Francisco EMA EIIHA Plan:

1. **Males Who Have Sex with Males (MSM)**
2. **People Who Inject Drugs (PWID)**
3. **Transgender Females Who Have Sex with Males (TGF/M)**

The San Francisco EMA's FY 2018 EIIHA target populations have been selected on the basis of **three** key factors. **First**, from an epidemiological standpoint, these three populations together encompass nearly **95%** of all persons currently living with HIV in the San Francisco EMA. MSM alone – including MSM who inject drugs – make up **85.4%** of all persons living with HIV cases in the region as of December 31, 2016, while non-MSM PWID make up another **6.4%** of all local PLWHA. **Second**, the populations represent the three groups most highly prioritized in the EMA's 2017-2021 Integrated HIV Prevention and Care Plan, which represents the product of intense study and collaborative planning. And **third**, the selected populations contain the highest rates of new HIV diagnoses as reported through HIV testing data for the period January 1 - December 30, 2016.

b. Challenges and Opportunities in Working with the Target Populations:

Perhaps the greatest challenge as the region approaches zero new HIV infections and 100% viral suppression is the continued prevalence of disparities along the continuum of care. While strategies implemented to date have benefited white gay men, other populations have not seen the same degree of benefit. For this reason, the new 2017-2021 Integrated HIV Prevention and Care Plan embraces a health equity approach to HIV prevention, care, and treatment as its focus going forward. The Plan includes numerous potential strategies to be considered by the merged Planning Council in addressing disparities, including:

- Implement a pilot mentoring program for young gay men and transfemales that supports the development and maintenance of personal strategies for supporting sexual health.
- Develop and implement a standard HIV curriculum for substance use and mental health providers, including culturally competent approaches for screening for HIV risk and referral and linkage resources.

- Develop and disseminate PrEP Standards of Care through the San Francisco Department of Public Health, including standards on administering, tracking, and managing PrEP
- Implement DPH transgender-specific sex and gender guidelines that adhere to specific data collection principles including the following: 1) Naming should be self-identified; 2) Transgender and sexual orientation data should be coded with caution and care when working with minors in consideration of the fact that health data are legally accessible by guardians; 3) information should be up-to-date; 4) Naming should allow for both consistency and relevance and compliance and comparability.
- Explore the creation of new program approaches to reduce HIV and hepatitis C infection among persons who inject drugs, including approaches that incorporate a harm reduction perspective.
- Develop and implement new models for integrating geriatric specialists into the HIV clinic setting.
- Recognize the growing shortage of physicians who are skilled in both HIV and geriatric care and advocate for the recruitment and training of specialists in these dual areas to address growing older HIV populations.
- Create a new level of specialized training and certification to create case management staff who are expert in the distinct system of services that exists for persons 50 and older.

c. <u>Strategies to be Utilized with the Target Populations:</u>

The San Francisco EMA will employ a broad range of strategies to expand awareness of, access to, and utilization of HIV testing and care services in the service region for persons who are currently unaware of their HIV status and for persons with HIV who have dropped out of or become lost to care. The list of objectives below outlines these activities in relation to the three FY 2018 target populations. All activities listed in the EIIHA Plan will be coordinated with activities conducted by the HIV prevention units in the three EMA counties as outlined in the integrated jurisdictional HIV Prevention Plans. All activities will also be coordinated to promote HIV prevention and care integration in the region.

San Francisco has also introduced the highly influential and impactful **Rapid Antiretroviral Program Initiative for New Diagnosis (RAPID),** a program that began at Zuckerberg San Francisco General Hospital 2 years ago and has expanded to HIV clinics city-wide. RAPID is a comprehensive initiative designed to help clients overcome the financial and social barriers to undergoing testing for HIV and being linked to care.[28] RAPID seeks to reduce the time between diagnosis, linkage to a primary care provider, antiretroviral initiation, and viral suppression. Through RAPID, five-day "treatment packs" are dispensed to new clients entering the clinic on the **same day** they have received an HIV diagnosis and a full set of labs are drawn and the patient meets with a social worker to ensure coverage for the continuance of the ART medications. RAPID not only promotes patient health through early engagement in treatment, but plays a significant role in preventing new infections by reducing infectivity when patients are experiencing acute HIV syndrome, during which they are at greatest risk to pass the virus on to others. The RAPID program is able to provide immediate medication linkage for clients linked at HIV testing

sites throughout San Francisco, and has been extremely effective in helping the city meet its long-term test and treat goals.

In addition to the activities listed below, San Francisco will also continue implementation of care access enhancement activities being made possible through the California Center for Medicaid and CHIP Services **Delivery System Reform Incentive Pool (DSRIP)** and its **Category V** program. This program was specifically designed to enhance the capacity of participating hospitals to develop programs to provide access to high-quality, coordinated, integrated care to patients diagnosed with HIV, particularly Low-**Income** Health program (LIHP) enrollees who previously received services through Ryan White funding. The San Francisco DSRIP Category V program is being implemented at Zuckerberg San Francisco General Hospital and is creating a range of specific HIV care enhancements, many of which are expected to expand the quality of care linkage and retention services in the region. This includes creation of a **model retention program** within patient-centered medical homes for persons with HIV, which began in April 2013 with a pilot program at San Francisco General Hospital for patients with high rates of missed primary care appointments as part of the ongoing PHAST program.

SMART Objectives for Each EIIHA Plan Component:

1. **MSM:**
   Between March 1, 2018 and February 28, 2019, to provide a total of at least **19,000** documented HIV antibody tests for MSM in the San Francisco EMA.
2. Between March 1, 2018 and February 28, 2019, to identify a total of at least **200** new or previously diagnosed HIV-positive individuals within this population.
3. Between March 1, 2018 and February 28, 2019, to ensure that at least **95%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
4. Between March 1, 2018 and February 28, 2019, ensure that at least **93%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
5. Between March 1, 2018 and February 28, 2019, ensure that at least **95%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
6. Between March 1, 2018 and February 28, 2019, ensure that at least **75%** accept partner services.

- **PWID:**

7. Between March 1, 2018 and February 28, 2019, to provide a total of at least **1,750** documented HIV antibody tests for PWID in the San Francisco EMA.
8. Between March 1, 2018 and February 28, 2019, to identify a total of at least **35** new or previously diagnosed HIV-positive individuals within this population.
9. Between March 1, 2018 and February 28, 2019, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
10. Between March 1, 2018 and February 28, 2019, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
11. Between March 1, 2018 and February 28, 2019, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
12. Between March 1, 2018 and February 28, 2019, ensure that at least **75%** accept partner services.

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

13. Between March 1, 2018 and February 28, 2019, to provide a total of at least **480** documented HIV antibody tests for transgender women who have sex with men in the San Francisco EMA.
14. Between March 1, 2018 and February 28, 2019, to identify a total of at least **11** new or previously diagnosed HIV-positive individuals within this population.
15. Between March 1, 2018 and February 28, 2019, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
16. Between March 1, 2018 and February 28, 2019, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
17. Between March 1, 2018 and February 28, 2019, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
18. Between March 1, 2018 and February 28, 2019, ensure that at least **75%** accept partner services.

C. AIDS Pharmaceutical Assistance

N/A - The SF EMA no longer allocated Part A funds to support the purchase of HIV-related pharmaceuticals.

- **METHODOLOGY**

A. Impact of the Changing Health Care Landscape

1. Overview of Regional Health Care Options:

The most important complementary funding stream to support HIV care for populations with low incomes is the **Medicaid** system, or **Medi-Cal**, as the system is known in California. Medi-Cal is an indispensable link in the chain of support for persons with low-incomes and HIV in the San Francisco EMA, and it has become an even more fundamental component with the advent of expanded ACA coverage. Between July 1, 2014 and June 30, 2015, the last date for which data is available, reimbursements for persons with HIV in the San Francisco EMA through Medi-Cal fee-for-service totaled **$60,909,907**. Fully **75.8%** of these expenditures (**$46,158,285**) supported the cost of HIV-related medications - **more than double** the proportion of Medi-Cal HIV funds being spent on pharmaceuticals in 2012. Another **10.9%** of Medi-Cal HIV funds supported long-term care (**$6,653,668**); **6.8%** supported hospital inpatient care (**$4,149,732**) and **4.7%** (**$2,884,477**) supported the cost of HIV care at clinics.[29] The San Francisco Planning Council examines changes in Medi-Cal data each year and takes this information into consideration in making its annual allocation of Part A primary medical care funding.

In addition to expanding Medicaid enrollment through LIHP, California was one of the very first states to develop a **state-based health insurance exchange** authorized by the ACA, which was conditionally approved to operate by the U.S. Department of Health and Human Services in 2011. The exchange, named **Covered California,** is essentially a **virtual marketplace** that allows citizens and legally recognized immigrants who do not have access to affordable employment-based coverage and are not eligible for Medicaid or other

public coverage to purchase subsidized health insurance if they earn up to 400% of FPL. Covered California health plans are also available to small employers through the Small Business Health Options Program (SHOP). In early 2013, the California Simulation of Insurance Markets (CalSIM) model predicted that at least 840,000 individuals with family incomes below 400% FPL would purchase insurance offered through Covered California and receive income-based premium tax credits to subsidize the out-of-pocket cost of coverage in 2014.[30] The vast majority of these individual are eligible for premium tax credits expected to range from 36 to 54% of enrollees in 2014.[31] However, during the historic first open-enrollment period from November 15, 2013 through April 15, 2014, more than **1.3 million** Californians chose health insurance through Covered California for coverage in 2014, while millions of additional Californians learned that they qualified for free or low-cost health coverage through Medicaid. Covered California today provides a critical bridge to affordable care for many persons with HIV in the San Francisco EMA whose incomes do not qualify them for expanded Medicaid coverage.

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

San Francisco also operates **Healthy San Francisco,** a program designed to make health care services available and affordable to uninsured San Francisco residents. Operated by the San Francisco Department of Public Health, Healthy San Francisco is available to all San Francisco residents regardless of immigration status, employment status, or pre-existing medical conditions and currently provides health coverage to over **50,000** uninsured San Francisco residents. To be eligible for Healthy San Francisco, enrollees must be a San Francisco resident and have income at or below **400%** of Federal Poverty Level. Depending on income, enrollees pay modest fees for health coverage. The City and County are currently working with the State of California to finalize an effective integration between the two programs that ensures that persons with HIV wishing to transfer from Healthy San Francisco to Covered California are able to retain their current provider or that they have effective options for receiving high-quality HIV specialist care from culturally appropriate providers.

The San Francisco EMA also relies on insurance co-payment options available 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 to individuals currently without health insurance who would like to purchase it. Since the implementation of the Affordable Care Act, the OA-HIPP has experienced a **63%** increase in the number of clients served by the program through June 30, 2015.[32] As of June 2014, 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. Because of this support, neither San Francisco nor San Mateo County is currently providing co-payments for individuals newly covered through ACA. Marin County funds a small number of annual co-payments on an emergency basis, to prevent individuals from losing insurance on a short-term basis. The regional AIDS Education and Training Center (AETC) provide regular training to ADAP sites throughout the EMA on the utilization of and application for OA-HIPP funding.

a. <u>How Coverage Options Limit Access to Direct Health Care Services:</u>

While initial ACA implementation involved several significant barriers to immediate health care access, these barriers have largely vanished as agencies have become more adept at rapidly enrolling and retaining clients in insurance and as systems have adapted to accommodate new insurance options and requirements. Initially, for example, patients experienced significant delays by needing to change their medical home away from their existing HIV clinical site and then re-designating that site as their specialty care provision center. Now, however, medical homes routinely assign new patients back to their HIV provider without the need for the client to ever access services at the medical home in order to receive a referral. The expanding options afforded through ACA have vastly increased the number of low-income persons with HIV in the SF EMA who are able to effectively access high-quality HIV care and support services whenever needed.

On the whole, Part A funding in the San Francisco EMA is able to address many of the direct care and support needs of low-income persons with HIV, including services for uninsured individuals and services that address shortfalls in Medicaid and other plan coverages. These resources are complemented by a range of public and private funds, including funds generated through the local Getting to Zero initiative. In regard to care services, additional funding for **mental health services, substance abuse treatment**, and **housing** would have a tremendous impact on retaining HIV-infected populations in care. Additional resources to fund **pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and Hepatitis C** treatment for persons for whom these treatments are not covered through insurance would also be of tremendous value.

2. <u>Changes in the Health Care Landscape:</u>

a. <u>Service Provision and Complexity of Care:</u>

The advent of health care reform and its aftermath has had welcome impacts on persons living with HIV in the San Francisco region. Expanded coverage has significantly broadened public insurance options for many low-income persons living with HIV who had formerly lied on the Ryan White system as their only source of funding for medical care and HIV treatment. While this initially created challenges for local HIV care providers in terms of enrollment, benefits counseling, and the exodus of some patients to local HMO systems, these impacts have now been largely absorbed, and the shift to new billing and insurance approaches has become routinized. Far from resulting in a reduction of low-income HIV patients at local clinics, the systemic change has in many cases increased the number of

new clients seeking services in order to quality for ADAP funding to cover medication shortfalls in private insurance plans.

b. Changes in Part A Allocations:

The advent of the Affordable Care Act resulted in dramatic shifts in both the expenditure and allocation of Part A funds in the San Francisco EMA. For example, while requested costs for outpatient / ambulatory health service made up **39.3%** of the EMA's total Part A funding request for the 2014 Ryan White fiscal year, that percentage has dropped to **24.2%** for the current FY 2018 funding request. Conversely, while medical case management costs needed to retain individuals in care made up only **9.1%** of requested Part A funds for FY 2014, they now make up **16.2%** of the current Part A grant request. Similar proportional funding increases have taken place in regard to mental health services (**8.7%** in FY 2014 vs. **12.7%** in FY 2017) and non-medical case management (**3.3%** in FY 2014 vs. **7.3%** in FY 2017). Expanded ACA-related reimbursements directly led to the EMA's decision to successfully apply for a waiver of the 75/25 primary care funding requirement beginning in FY 2014, in order to shift expenditures that had formerly gone to support Core Medical Services into support for essential Support Services that play a critical role both in retaining persons with HIV in care and ensuring better long-term medical adherence.

B. Planning Responsibilities

1. Planning and Resource Allocation:

a. Description of the Community Input Process:

As in previous years, the San Francisco EMA employed a **multi-phased process** for FY 2018 priority-setting and allocations. This process began early in the year with planning meetings of the former Council's Steering Committee to assess preliminary data and develop a set of initial prioritization recommendations. Planning Council members also conducted a review of progress toward the Objectives and Action Steps contained in its new 2017-2021 Integrated HIV Prevention and Care Plan. A broad range of background materials and information were presented to the Council to provide a background to current service access and funding trends in the EMA. The Council discussed resource allocation funding scenarios within committees throughout September 2017 and then voted on resource allocation funding scenarios at its annual **Prioritization and Allocation Summit** which took place in San Francisco on **October 3, 2017**. The Summit included an analysis and discussion of trends and factors in the EMA, including review of epidemiological information, client data, and HIV funding in the EMA, including Ryan White and Medicaid funding. This was followed by a discussion and vote on FY 2018 resource allocations for the EMA and development of funding scenarios to help cope either with potential increases or decreases in Part A funding.

Since its inception, the San Francisco Planning Council has utilized a wide range of quantitative and qualitative data to help Planning Council members assess needs, measure progress, identify gaps, prioritize services, and allocate resources. The Council has also

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

i. How PLWH are Involved in the Planning and Allocation Process: As in previous years, persons living with HIV (PLWHs) were integrally involved in all phases of the FY 2018 priority-setting and allocation process. Prior to the convening of the new merged council, **15** self-identified persons living with HIV served on the San Francisco HIV Health Services Planning Council, comprising **65%** of total Council membership. Council bylaws require that at least one Council Co-Chair be a person with HIV and a consumer of Ryan White services, and the Council strives to ensure that at least one co-chair for each committee is a person with HIV.

The Council also relied on a series of **issue and population-focused needs assessments** which replaced the comprehensive needs assessment process that was last conducted in our region in 2008. Since 2010, the Council has commissioned and conducted needs assessments focusing on **Transgender Women** (2012); the **HIV and Aging Population** (2013); **Latino MSM** (2103); **MSM Users of Crystal Meth** (2104); **Asian & Pacific Islanders** (2015); **African-Americans** (2015); **Clients with Mental Health Challenges** (2016); and **HIV-Positive Homeless and Unstably Persons** (2017). Each needs assessment utilizes a range of methodologies such as focus groups, surveys, and key informant interviews and includes a summary of recommendations which the Council uses to discuss needs and issues around specific topic areas and populations to influence the prioritization and allocation process. In the case of this year's Homeless and Unstably Housed Needs Assessment, for example, a total of **74** HIV-positive consumers provided direct input into the study's findings and recommendations. The smaller-scale needs assessment approach allows the Council to focus on current and emerging issues and populations as they arise, in order to provide relevant and rapid responses to local needs.

ii. How Community Input Was Considered and Applied: The Planning Council's current process of conducting annual, issue-focused needs assessments facilitates wide-ranging and consistent input by HIV-infected and affected consumers into the Council's

prioritization and allocation decision-making. Each Planning Council meeting also incorporates structured, set-aside time for community comments and input in association with each decision-related agenda item. Each year, the Planning Council also receives and considers specific recommendations from the **San Francisco HIV Provider Network**, a group of 43 community-based, non-profit HIV service agencies in the San Francisco EMA meeting the needs of persons living with HIV

iii. How MAI Funding Was Considered: As in previous years, the Planning Council reviewed a comprehensive summary of the specific services currently funded through Minority AIDS Initiative funding, and incorporated MAI allocations decisions into its overall FY 2018 allocations process. The summary detailed specific goals of the local MAI process; historical funding levels received in the region; previous and current expenditures with that funding; specific outcomes achieved in regard to minority health, health access, and service utilization; and a quantified report on the demographics of populations served through MAI funding. This report validated the success of the EMA's approach to MAI allocations, and affirmed the key role that MAI funding plays in helping reduce HIV disparities while meeting the needs of historically underserved populations.

iv. How Data Were Used in Priority Setting and Allocation: The Planning Council received and reviewed a broad range of high-quality data – including unmet needs data – to assist in prioritizing FY 2018 services and allocating resources, with an emphasis on HRSA-identified core medical services. Among the data presented, reviewed, discussed, and incorporated by the Council in its decision-making this year were the following:

- Background information on requirements and parameters of the Ryan White HIV Treatment Extension Act of 2009, including definitions of core service categories;
- A detailed analysis of each priority service category funded and not funded by the Council in FY 2017 by county, including service definitions; budgeted and actually funded service category amounts; populations served; key points of entry; utilization reviews; other funding sources available in each category; and possible impacts of cuts in each service category;
- A comprehensive, updated 2016 HIV Epidemiology Report by the SF Population Health Division detailing current PLWH populations and discussing current trends in the epidemic;
- A detailed analysis of client-level data reported through the ARIES data system for the period March 1, 2016 through February 28, 2017, including information on the demographic characteristics and changing health status of Ryan White-supported clients and service utilization data related to all Part A services;
- A summary of findings from the most recent needs assessments commissioned by the Planning Council, including the Comprehensive Assessment and Follow-Up Qualitative Study;
- A summary estimate of unmet need among PLWH in the San Francisco EMA utilizing HRSA's unmet needs framework;
- A detailed presentation on other funding streams in the EMA, with a special focus on federally funded programs and on programs funded through MAI support, as well as Part B, Part C, Part D, and Part F funding through the San Francisco Department of Health, and other sources;

- A review of goals and objectives from both the 2012-2014 Comprehensive HIV Health Services Plan and the new 2017-2021 Integrated Prevention and Care Plan; and
- Consensus input to the Planning Council from the San Francisco HIV Provider Network, a group of 43 community-based, non-profit HIV service agencies in the San Francisco EMA meeting the needs of persons living with HIV.

v. Significant Prioritization and Allocation Changes from FY 2017 to FY 2018: No significant prioritization and allocation changes took place between the current Part A fiscal year and the upcoming 2018 fiscal year. However, as a direct result of ACA implementation, the Council has successfully applied for a waiver of the 75/25 Part A core medical services funding requirement each year since 2014, and plans to do so for the upcoming 2018 fiscal year as well. The waiver request is in direct response to the declining demand for Part A funding to support ambulatory outpatient care as a result of increased ACA-related reimbursements. The FY 2018 funding request continues a pattern of reductions in the proportion of Part A funding requested to support outpatient medical care.

2. Administrative Assessment:

a. Assessment of Grant Recipient Activities:

In 2016, prior to its merger with the Prevention Planning Council, the San Francisco EMA HIV Community Planning Council conducted a comprehensive assessment of the regional Ryan White Part A grantee agency, the San Francisco Department of Health Services HIV Health Services unit. This marked the first time that the Council had undertaken a formal assessment in over half a decade. The assessment involved **four** key Part A constituent groups: a) Part A-funded providers; b) Planning Council members; c) Planning Council staff; and 3) Staff of San Francisco HIV Health Services (HHS). The methodology for the assessment included an anonymous, online survey for all participants; key information interviews involving HIV service providers; and series of 3 focus groups, one each involving Council members, Council staff, and Grantee staff.

The overall response to the work of the local Part A grantee was extremely positive. Several members Council referred to the relationship between the Council and HIV Health Services as a **partnership,** with Council members reporting a high level of transparency from the Grantee. Several Council members commented on the value of having HHS representation at every meeting. Aggregated Council responses to the online survey were as follows:

Survey Question	Total Score out of 5
How well does the grantee support the Council?	4.75
How timely and complete are presentations or information presented by grantee staff?	4.33
How well does HHS support the prioritization & allocation process?	4.25

Survey Question	Total Score out of 5
How timely, well-prepared, and helpful are the presentations brought to the Planning Council by grantee staff?	4.25
How well does HHS support the process of allocating carry-forward dollars?	4.50

Consensus findings of the Administrative Assessment across all input group consisted of the following:

- Key stakeholders across the board defined their relationship with the grantee as a partnership, and expressed appreciation for a high level of responsiveness and a general spirit of shared vision.
- Council members and council staff emphasized the importance of grantee transparency in the allocation process, and expressed confidence that services funded by the grantee address the Council's priorities and instructions for allocating dollars.
- Providers reported concerns around the long and complicated process of contract certification, but reported no adverse impact on clients due to delays in reimbursement.
- Providers reported a high level of responsiveness from HHS and CDTA, and reported that the procurement and monitoring processes are fair.
- The grantee self-assessed the administrative mechanism as very effective, and expressed an openness to receive feedback and a desire to continually seek improvement.

b. Strategies to Address Deficiencies:

Because the Planning Council's Administrative Assessment did not identify any deficiencies in its assessment of grant recipient activities, **no** corrective actions needed to be taken in response to assessment findings.

3. Letter of Assurance from Planning Council Chairs:

Please see Planning Council letter in **Attachment 6.**

4. Resource Inventory:

a) Coordination of Services and Funding Streams:

i. Jurisdictional HIV Resources Inventory: Please see table in **Attachment 5.**

ii. Narrative Resource Inventory Description: The San Francisco HIV Health Services Planning Council and the SF Department of Public Health work together to ensure that Ryan White Part A funds are coordinated across all applicable funding streams in the region and that they address identified service gaps at all levels of client care and support. The Planning Council reviews annual service category summaries that include a detailed listing of all Ryan White and non-Ryan White funding sources for each category, including

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

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

- **WORK PLAN**

A. HIV Continuum Table and Narrative

1. <u>HIV Care Continuum Table:</u> Please see table in **Attachment 7.**

2. <u>HIV Care Continuum Narrative:</u>

a. <u>How the Care Continuum is Utilized in Planning and Prioritization:</u>

The continuum of care framework embodies an approach to comprehensive care which has an increasingly important impact on HIV prevention and service planning in the San Francisco region. The Continuum of Care offers clear benchmarks to track our progress toward key HIV outcomes in the region, and allows us to compare our own regional outcomes to outcomes in other health jurisdictions. At the same time, analysis of continuum-related disparities shows us where we are falling short in terms of reaching and serving specific HIV-affected subpopulations and serves as a guide to allow us to more effectively allocate resources to eliminate disparities and achieve health equity. The Planning Council reviews the region's most recent Continuum of Care during its annual prioritization and allocation process - along with a corresponding disparities analysis - to ensure that its funding strategies will continue to have the greatest impact on all aspects of the Continuum, with the ultimate goal of achieving viral suppression among the greatest possible number of PLWH in our region.

At the same time, the Continuum reflects and enhances a **merged vision of HIV prevention and care** which is embodied by our region's recent merger of our former HIV care and prevention planning councils into a single merged planning body - the San Francisco HIV Community Planning Council. The Council's philosophy and approach builds from the concept of **treatment as prevention** in order to address HIV as a **holistic health issue**. This approach sees HIV prevention, care, and treatment as being **inextricably**

intertwined, and prioritizes the needs of people **regardless of HIV status**. This creates a context that allows affected communities to come together around a common vision and set of priorities, including ensuring access to health care and other services; providing a continuum of HIV prevention, care and treatment services using a holistic approach; and ultimately, as a result, "getting to zero" - meaning zero new infections, zero AIDS-related deaths, and zero stigma – may be within our reach for the first time in the history of the epidemic.

b. How the Impact of the HIV Care Continuum is Evaluated:

The merged San Francisco HIV Community Planning Council hosts regular presentations and updates on the local continuum by staff of the San Francisco Department of Public Health and considers disparities in continuum outcomes in regard to sub-populations when making prioritization and allocation decisions and planning prevention strategies and services. The Department itself utilizes continuum outcomes as a strategy to assess the effectiveness of the local prevention and care system in meeting existing and emerging prevention and care needs, and to plan enhanced services and programs to better address shortfalls in continuum targets.

B. Funding for Core and Support Services

1. Service Category Plan:

a) Service Category Plan Table: Please see table in **Attachment 8.**

b) Service Category Plan Narrative:

The FY 2018 Part A Plan requests a total of **$16,601,550** in Formula and Supplemental funding to allow the SF EMA region to continue to meet escalating client needs in an effective and strategic manner. Direct service allocations make up **89.0%** of this total request, for a total of **$14,774,136**. Another **$350,000** supports EMA-wide quality management activities while **$1,477,414** supports administrative costs for the recipient agency, including San Francisco Planning Council expenses. Reflecting HIV caseload proportions in the EMA's three counties, a total of **8.5%** of the FY 2018 direct service request supports HIV client services in **San Mateo County**, while another **3.5%** supports direct HIV services in **Marin County**. The remaining service allocation supports persons living with HIV in the City and County of San Francisco.

The large majority of proposed FY 2018 service expenditures – **68.5%** of total requested service dollars (**$10,101,592**) - support the provision of direct care services in HRSA-identified **core service categories**. Of this year's total direct service request, a total of **$3,570,264** is requested for **outpatient / ambulatory health services** (including **$525,138** in Part A MAI funds), an amount representing **35.3%** of the total core services request and **24.2%** of the total FY 2018 direct service budget. This category includes support for ambulatory care services delivered in community and institutional settings as well as the **seven regional Centers of Excellence** that build upon and enhance San Francisco's highly successful integrated services approach to care. Additional HRSA core

categories for which funding is requested in the FY 2018 Plan include: a) **Medical Case Management** that links and coordinates assistance from multiple agencies and caregivers in order to ensure access and adherence to medical treatment (**$2,393,804,** including **$196,482** in requested MAI funds); b) **Mental Health Services,** including Crisis and Outpatient Mental Health Services (**$1,875,087**); c) **Oral Health Care** to address critical dental manifestations of HIV and preserve overall client health (**$862,011**); **d) Hospice Services** supporting room, board, nursing care, counseling, physician services, and palliative care for clients in terminal stages of illness (**$733,410**); and e) **Home Health Care** to meet direct medical treatment needs outside of inpatient and clinical settings (**$487,923**).

The San Francisco EMA utilizes Part A **MAI funds** specifically to support services for **low-income HIV-infected Latino and Latina populations.** While some service dollars incidentally support other populations of color with HIV, local MAI funds are almost exclusively focused on ensuring culturally and linguistically appropriate services to this large and rapidly growing PLWH population. Latinos are the fastest growing group of HIV-infected persons in the EMA by ethnicity, making up **32.4%** of all new HIV diagnoses in CY 2016 alone. Between 2011 and 2016, Latino PLWH in the EMA grew from **15.5%** to **22.1%** of total PLWH living in our region. According to the Pew Research Center, **29%** of Hispanics in California lack any form of health insurance and **25%** of Hispanics 17 and under live below the Federal Poverty Line.[33]

The primary manner in which MAI funds ensure quality care access for communities of color is through funding of the **Mission Center of Excellence** that has been established in the heavily Latino Mission district by **Mission Neighborhood Health Center.** The Mission CoE addresses what is both the fastest growing and one of the most highly impoverished communities in San Francisco in terms of HIV infection. 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 Latino clients. In addition to supporting the cost of direct medical/ambulatory health services through a staff of five bilingual/bicultural professionals, MAI funding also helps support the cost of medical case management, psychiatric, treatment adherence, and mental health counseling services. MAI-funded peer and treatment advocates also help clients make informed decisions about medications, and work with them to identify and remove barriers to adherence.

Minority AIDS Initiative funds have had a major impact on the San Francisco EMA, allowing us to identify, reach, and bring into care a significant number of highly disadvantaged persons of color, in turn reducing service disparities and improving health outcomes across the region. FY 2016-2017 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.

- **RESOLUTION OF CHALLENGES**

Please see table beginning on the following page.

Challenges & Barriers	Proposed Resolutions	Intended Outcomes	Current Status
▪ **Rapidly aging population of persons 50 and older with HIV**	▪ Continue to develop models of enhanced geriatric assessment and care in HIV clinical settings ▪ Expand linkages between geriatric and HIV service communities ▪ Expand consumer involvement in designing and implementing effective support programs for older PLWH ▪ Explore opportunities to meet the unique psych-social and behavioral support needs of aging, long-term survivors of HIV.	▪ Improved health outcomes of older PLWH ▪ Enhanced long-term retention of older adults with HIV in care ▪ Improved access to community aging services and resources for older PLWH	▪ SF recently completed the Silver Project, a demonstration project to incorporate expanded aging assessment and geriatric consultation in HIV clinical settings ▪ Ryan White funds have helped support the creation of an aging specialty clinic at SF General Hospital ▪ Ryan White Part D funds have been requested to launch the nation's first specialty clinic for older women with HIV at SF General Hospital
▪ **Continued high impact of HIV among homeless populations**	▪ In February 2017, the SF Planning Council's Community Engagement Committee formed a Homeless and Unstably Housed Needs Assessment Work Group to identify needs of homeless persons with HIV ▪ In September 2017, the Work Group presented findings of a Homeless and HIV needs assessment involving input from 74 unstably housed PLWH ▪ SFDPH incorporates training and TA on enhanced identification and service to homeless 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 recently completed a five-year HRSA SPNS grant to develop and test new integrated system of HIV care and support for homeless PLWH ▪ SF identified funding to continue key aspects of the multi-service clinical model developed through the SPNS grant ▪ The SF Planning Council incorporated recommendations from the Homeless and Unstably Housed Needs Assessment Work Group in the FY 2018 prioritization and allocation process
▪ **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	▪ Ensure ongoing, long-term medication and adherence and care retention to preserve and expand high levels of viral suppression and continue progress toward reduced HIV cases	▪ 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

Challenges & Barriers	Proposed Resolutions	Intended Outcomes	Current Status
	▪ Explore new methods for expanded involvement of consumers and peers in clinic-based client retention support roles	▪ 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	▪ The SF Planning Council prioritizes Part A funding to support long-term care retention and medication adherence activities. ▪ SF assigned local General Funds to create and support a mobile-engagement based Integrated Case Management program to provide higher level of support for high acuity clients to retain retention in care.
▪ **Need to better track pre-exposure prophylaxis (PrEP) use in order to identify and address PrEP disparities**	▪ Develop expanded methodologies to track PrEP utilization within public and non-publicly funded medical and clinical settings, including demographic information on PrEP users ▪ Involve consumers in planning effective PrEP education, outreach, and linkage activities to reach underserved subpopulations ▪ Continue to advocate for new State regulations that allow reporting of PrEP medication prescriptions for HIV-negative persons	▪ Better knowledge of which subpopulations are and are not using PrEP in order to effectively target PrEP outreach, education, and resources ▪ Better knowledge of effective ways to recruit subpopulations that are under-utilizing PrEP ▪ Access to region-wide data on utilization of PrEP medications	▪ SFDPH continues to reach out to public and non-publicly funded clinical providers throughout the EMA to obtain a better picture of the number and characteristics of persons enrolled in PrEP in the region ▪ The SF EMA continues to support new State regulations that will allow access to data on PrEP pharmaceuticals for HIV-negative persons
▪ **Need to better enhance HIV identification and tracking systems in San Mateo and Marin Counties**	▪ Provide support through SFDPH for enhanced case finding efforts in San Mateo and Marin Counties, including better identification of high-risk areas and populations ▪ Provide support through SFDPH for enhanced epidemiological tracking systems to better monitor outcomes and outcome disparities in the two counties	▪ Improved HIV prevention and outreach in San Mateo and Marin Counties ▪ Improved HIV case data in the two counties ▪ Enhanced integration of HIV data across the EMA, resulting in production of a reliable EMA-wide Care Continuum chart	▪ The new five-year Integrated HIV Prevention & Care Plan incorporated specific, five-year targets for supporting San Mateo and Marin Counties in enhancing case finding and tracking systems ▪ Planning Council Plan monitoring will incorporate tracking of systems enhancement in the two counties throughout the life of the Plan

San Francisco Department of Public Health
Greg Wagner
Acting Director of Health

City and County of San Francisco
London N. Breed
Mayor

August 31, 2018

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

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

Dear Ms. Cavillo:

Attached please find an original and two copies of a proposed resolution for the approval of the Board of Supervisors, which authorizes the San Francisco Department of Public Health (SFDPH) to submit an application for the Ryan White Act HIV/AIDS Emergency Relief Grant Program (Ryan White Programs, Part A) to the Health Resources Services Administration (HRSA). This application is required to receive continued funding for the period of March 1, 2019 to February 29, 2020. This application represents approximately $16,202,223 in funding for the San Francisco Eligible Metropolitan Area (EMA). The San Francisco EMA includes the City and County of San Francisco, Marin County and San Mateo County. The funding supports a multitude of health services to HIV positive persons residing in these three counties.

This resolution is required by Ordinance No. 265-05, which amends Section 10-170 of the Administrative Code to require Board of Supervisors review of recurring grant applications of $5,000,000 or more prior to their submission. SFDPH received from HRSA the application guidance on June 4, 2018. The application deadline is September 21, 2018.

I hope that the Board will support this resolution. If you have any questions regarding the County Plan or this resolution, please contact Dean Goodwin HIV Health Services Assistant Director at 628-206-7675.

Sincerely,

Greg Wagner
Acting Director of Health

Enclosures

cc: Bill Blum, Director of Program SFDPH Primary Care & Director of HIV Health Services
Dean Goodwin, HIV Health Service Section Administrator
Sajid Shaikh, Sr Admin Analyst, Community Programs Business Office

OFFICE OF THE MAYOR
SAN FRANCISCO

LONDON N. BREED
MAYOR

TO: Angela Calvillo, Clerk of the Board of Supervisors
FROM: Mayor London Breed
RE: Grant Application - Health Resources Services Administration - Ryan White Act HIV/AIDS Emergency Relief Grant Program - $16,202,223
DATE: September 11, 2018

Resolution authorizing the Department of Public Health to submit an application to continue to receive funding for the Ryan White Act HIV/AIDS Emergency Relief Grant Program grant from the Health Resources Services Administration, requesting $16,202,223 in HIV Emergency Relief Program funding for the San Francisco Eligible Metropolitan Area for the period of March 1, 2019, through February 28, 2020.

Please note that Supervisor Mandelman is a co-sponsor of this legislation.

Should you have any questions, please contact Kanishka Karunaratne Cheng at 415-269-1819.

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