Attachment A

OMB Number: 4040-0004
Expiration Date: 12/31/2019

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [ ] New
- [x] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier: 94-6000417

5b. Federal Award Identifier: H89HA00006

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: San Francisco Dept of Public Health

* b. Employer/Taxpayer Identification Number (EIN/TIN): 94-6000417

* c. Organizational DUNS: 1037173360000

d. Address:

* Street1: 1380 Howard St, 4th Fl
Street2:
* City: San Francisco
County/Parish:
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 94103-2638

e. Organizational Unit:

Department Name: San Francisco Dept of Public H

Division Name: HIV Health Services

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:
* First Name: bill
Middle Name:
* Last Name: blumn
Suffix:

Title: Director of HIV Health Services

Organizational Affiliation:

* Telephone Number: 628-206-7672
Fax Number:

* Email: bill.blum@sfdph.org

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Health Resources and Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.914

CFDA Title:

HIV Emergency Relief Project Grants

*** 12. Funding Opportunity Number:**

HRSA-19-033

* Title:

Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program

13. Competition Identification Number:

HRSA-19-033

Title:

Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program

14. Areas Affected by Project (Cities, Counties, States, etc.):

Areas Affected by Project.pdf | Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Ryan White HIV/AIDS Part A - HIV Emergency Relief Grant Program

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: 12 * b. Program/Project: 12

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 03/01/2019 * b. End Date: 02/29/2020

18. Estimated Funding ($):

* a. Federal	16,202,223.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	16,202,223.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☒ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name: Roxana

Middle Name:

* Last Name: Castellon

Suffix:

* Title: Director of Operations

* Telephone Number: 415-657-1775 Fax Number:

* Email: roxana.castellon@sfdph.org

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

Areas Affected by Project

The FY 2019 San Francisco EMA Ryan White Part A Emergency Relief Grant Program will be implemented in the following California regions:

- **Marin County**
- **San Francisco County**
- **San Mateo County**

FY 2019 SAN FRANCISCO EMA RYAN WHITE PART A PROJECT ABSTRACT

Project Title: Building a Model for Ending HIV: San Francisco EMA FY 2019 Ryan White Part A Competing Continuation Application
Applicant Name: San Francisco HIV Health Services
Address: 25 Van Ness Avenue, Suite 500, San Francisco, CA, 94102
Project Director: Bill Blum, Director, HIV Health Services
Contact Numbers: Office: (415) 554-9105 / Fax: (415) 431-7547
E-Mail Address: bill.blum@sfdph.org / **Web Address:** www.sfhivcare.com
Total Funds Requested in Application: $16,202,223

General TGA Demographics: As of July 2016, the estimated population of the San Francisco (SF) EMA is **1,896,335** including 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 among the three regions. **Over half** of the EMA's residents are people of color, including large Asian/Pacific Islander (**29.6%**), Latino (**19.2%**), and African American (**4.1%**) populations. Over **42%** of EMA residents speak a language other than English at home.

HIV Overview: As of December 31, 2017, a total of **15,573** persons were living with diagnosed HIV in the SF EMA, for an EMA-wide HIV infection incidence of **821.2** cases per 100,000 persons. The HIV incidence in the city of San Francisco is **1,504.4** cases per 100,000 - the largest concentration in the nation outside of New York City. The epidemic disproportionately impacts men who have sex with men (MSM), who make up **85.5%** of all PLWH in the region, including MSM who inject drugs. Fully **60.0%** of all PLWH in the EMA are age 50 and older, most of whom are long-term survivors. Between December 2009 and December 2017, the number of persons 50 and over with HIV increased by **43%** while the number of PLWH 65 and older increased by **91.2%** over the last 24 months alone.

Continuum of Care: Throughout the EMA, the emphasis on **high-quality, client-centered primary medical care services** is at the heart of the continuum of care, with medical case management providing individualized coordination and entry points to a range of medical and social services. In addition to major hospitals in the EMA, there are **seven** public clinics and **six** community clinics in San Francisco County, **two** public clinics in San Mateo County, and **one** public clinic in Marin County providing HIV/AIDS primary care. San Francisco's **seven Centers of Excellence** form an innovative network of HIV providers designed to involve and retain complex, hard-to-reach, and multiply diagnosed populations in care. San Francisco was one of the 16 original Title I EMAs funded by the Ryan White CARE Act in **1991** and first began receiving MAI funding in **1999**.

Continuum-Related Successes and Challenges: The San Francisco EMA has achieved an unprecedented level of success in reducing the number of persons with HIV in the EMA who are unaware of their serostatus, currently estimated at **less than 4%.** At the same time, the EMA's viral load suppression rate of **72%** far surpasses the national average of **60%**. Through aggressive local prevention and care efforts, the number of new HIV infections in SF also continues to decrease. The total of **325** new cases of HIV infection diagnosed in the SF EMA in calendar year 2017 is the fewest number of regional new infections in the history of the HIV epidemic, while the **221** new HIV cases diagnosed in San Francisco represents a **16% reduction** over the past two years, and a **49% reduction** over the past five years, from 2012 to 2017.

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	Attachment 1. Staffing Plan.p	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	Attachment 2. Agreements and	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	Attachment 3. HIV Demographic	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	Attachment 4. Co-Occurring Co	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	Attachment 5. Coordination of	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	Attachment 6. Planning Counci	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	Attachment 7. HIV Care Contin	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8	Attachment 8. Service Categor	Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10	Attachment 10. Organizational	Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11	Attachment 11. Maintenance of	Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12	Attachment 12. Intergovernmen	Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

Attachment 1. San Francisco, California EMA FY 2019 Ryan White Part A Staffing Plan and Job Descriptions

Position Title	FTE on Project	Name of Incumbent	Brief Summary of Position Responsibilities / Rationale
Director of HIV Health Services	.40	William S. Blum	Charged with primary oversight for the administration of services and day to day operations of HIV Health Services and the Ryan White Part A grant.
Director of Contractual Development & Technical Assistance	.20	Michelle Long	Charged with oversight of contract development, modifications, and renewals of all Ryan White Part A grant
Director of Contractual Compliance	.50	Debra Solomon	Charged with oversight of contract compliance, contractor monitoring and reporting, and auditing
Health Program Coordinator III	1.35	Francine Austin, Marcia Herring	Charged with contract development, programmatic oversight and monitoring of Part A- MAI programs
Health Program Coordinator III	.15	Joseph Cecere	Administrator of the HIV Health Services client services database (ARIES) is responsible for the staffing of the ARIES user trainings, managing the coverage for the ARIES helpdesk line and overall implementation and planning for communications, updates, and oversight of this system.
Health Program Coordinator II	.10	Kevin Hutchcroft	Charged with programmatic oversight and monitoring of Part A programs. Also liaisons with HIV Community Planning Council and attends committee meetings.
HIV Administrator	.05	Dean Goodwin	Responsible for the overall planning, evaluation and quality management for HHS as the grantee for the San Francisco HIV System of Care in coordination with our Ryan White mandated HIV Health Services Planning Council.
Epidemiologist III	.33	Anne Hirozawa	Principal duties include for data quality, statistical analysis, and interpretation of findings, manuscript preparation and dissemination of findings. She supervises epidemiologist, data entry and data management
Principal Administrative Analyst	.30	Irene Carmona	Supervises contract staff and assures contract development compliance
Sr. Administrative Analyst	.35	Nora Macias, William Gaitan	Processes contracts and ensure compliance with government regulations
Sr. Accountant	.26	Vacant	Processes J/Es and claims reimbursement and performs expenditure analysis / reconciliation
Accountant	.75	Two Positions – Acct Interns	This position is responsible for grant accounts payable activities and reconciles with expenditure reports and claims.

FY 2019 SAN FRANCISCO EMA RYAN WHITE PART A APPLICATION

KEY STAFF BIOSKETCHES

- **William S. Blum, Interim Director of HIV Health Services:**

  Bill Blum, L.C.S.W has worked in the HIV field for the past thirty years. He has served as the Director of the San Francisco Department of Public Health (SFDPH) HIV Health Services for the since 2011 when he was promoted from Assistant Director, a role in which served since 2006. Since 2013, Mr. Blum has also served as the Director of Programs for SFDPH Primary Care. From 1996-2006, Mr. Blum worked at San Mateo County AIDS Program serving in a variety of roles, first as a social worker then as Director of Client Services, eventually becoming the program's Assistant Director. Prior to his transition to administrative work, Mr. Blum provided direct case management and mental health services for over a decade to diverse individuals and communities impacted by HIV in a variety of settings, including MSM in the AIDS Ward St Vincent's Voluntary Hospital in New York City; homeless street youth engaged in sex work at Hetrick Martin Institute for the Protection of Lesbian and gay youth, also in NYC; gay and MSM at Project Stop AIDS in Rio Piedras; injection drug users and their partners at the San Juan Veterans Administration; and recent Latino/a/x immigrants in San Mateo County. Mr. Blum served on the San Francisco EMA Ryan White Planning Council from 2001 through 2015 when it transitioned to the SF EMA HIV Community Planning Council. Mr. Blum has a B.A. in psychology from Cornell University and an M.S.W. from Hunter College School of Social Work.

- **Michelle Long, Director of Contract Development & Technical Assistance**

  Michelle Long is currently the Director of Contract Development and Technical Assistance for the San Francisco Department of Public Health where she is responsible for the development of approximately $240 million in contracting annually, including HIV service and prevention contracts. Her focus has been on developing innovative infrastructure systems within DPH and providing technical assistance to executive directors and boards of directors of non-profit organizations. Prior to her current position, Ms. Long was the Director of HIV Health Services for SFDPH, responsible for the administration of the Ryan White and other Federal and State grants that fund treatment and care services for persons with HIV disease for the San Francisco Eligible Metropolitan Area, which encompasses San Francisco, San Mateo and Marin Counties. Michelle has been recognized for her innovative work with Ramsell Corporation in the development and implementation of the San Francisco AIDS Drug Assistance Program, a model which increases access to medications for persons with HIV disease through neighborhood pharmacies and community based organizations. This model became the prototype for the statewide system that is utilized in California and several other states currently. Her accomplishments include receipt of the Hank Carde Award for Metropolitan Services in 2006 from the U.S. Health Resources and Services Administration for implementation of an integrated services model of care to better serve multiply-diagnosed individuals with HIV/AIDS as well as contributions to the development of the prototype medication distribution system.

- **Debra Solomon, Director of Contract Compliance**

  Debra Solomon is the Director of Contract Compliance for the San Francisco Department of Public Health. In this role, she and her staff have responsibility for monitoring the compliance, performance, and fiscal health of more than 350 contracts and public health programs. Ms. Solomon has more than twenty years of experience in program evaluation, nonprofit management, and contract management, with a special focus on using research and data analysis to improve services for the Bay Area's low-income and vulnerable populations. As a consultant for the National Economic Development and Law Center, she worked with communities around the Bay Area and around the United States to develop effective job training and economic development programs. In 2005, she began working for the City of San Francisco, where she has held a number of roles. As Senior Budget and Policy Analyst and Contracts Manager for the San Francisco Human Services Agency, she developed a deep expertise in effective budgeting and performance management for social service and public health programming. Ms. Solomon received a bachelor's degree from Stanford University and a master's in public policy from the University of California, Berkeley. She is a 2017 graduate of Leadership San Francisco.

Appendix A
FY 2019 AGREEMENTS AND COMPLIANCE ASSURANCES
Ryan White HIV/AIDS Program
Part A HIV Emergency Relief Grant Program

I, the Chief Elected Official of the **San Francisco Eligible Metropolitan Area**, (hereinafter referred to as the EMA) assure that:

Pursuant to Section 2602(a)(2)[1][2]
The EMA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

Pursuant to Section 2602(a)(2)(B)
The EMA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA that provide HIV-related health services and for which the number of AIDS cases in the last 5 years constitutes not less than 10 percent of the cases reported for the EMA.

Pursuant to Section 2602(b)(4)
The EMA Planning Council will determine the size and demographics of the population of individuals with HIV/AIDS, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status; determine the needs of such population, and develop a comprehensive plan for the organization and delivery of health and support services. The plan must include a strategy with discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of their HIV status, and enabling such individuals to use the health and support services. The strategy should particularly address disparities in access and services among affected subpopulations and historically underserved communities.

Pursuant to Section 2603(c)
The EMA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)
The EMA will make expenditures in compliance with priorities established by the Planning Council/Planning Body.

Pursuant to Section 2604(a)
The EMA will expend funds according to priorities established by the Planning Council/Planning Body, and for core medical services, support services, and administrative expenses only.

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[1] All statutory references are to the Public Health Service Act, unless otherwise specified.
[2] TGAs are exempted from the requirement related to Planning Councils, but must provide a process for obtaining community input as described in **section 2609(d)(1)(A)** of the PHS Act. TGAs that have currently operating Planning Councils are strongly encouraged to maintain that structure.

Pursuant to Section 2604(c)
The EMA will expend not less than 75 percent of service dollars for core medical services, unless waived by the Secretary.

Pursuant to Section 2604(f)
The EMA will, for each of such populations in the eligible area expend, from the grants made for the area under Section 2601(a) for a FY, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS, unless a waiver from this provision is obtained.

Pursuant to Section 2604(g)
The EMA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary.

Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)
The EMA will expend no more than 10 percent of the grant on administrative costs (including Planning Council or planning body expenses), and in accordance with the legislative definition of administrative activities, and the allocation of funds to subrecipients will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

Pursuant to Section 2604(h)(5)
The EMA will establish a CQM Program that meets HRSA requirements, and that funding for this program shall not exceed the lesser of five percent of program funds or $3 million.

Pursuant to Section 2604(i)
The EMA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)
With regard to the use of funds,

a. funds received under Part A of Title XXVI of the Act will be used to supplement, not supplant, state funds made available in the year for which the grant is awarded to provide HIV related services to individuals with HIV disease;
b. during the period of performance, political subdivisions within the EMA will maintain at least their prior FY's level of expenditures for HIV related services for individuals with HIV disease;
c. political subdivisions within the EMA will not use funds received under Part A in maintaining the level of expenditures for HIV related services as required in the above paragraph; and
d. documentation of this MOE will be retained.

Pursuant to Section 2605(a)(3)
The EMA will maintain appropriate referral relationships with entities considered key points of access to the health care system for the purpose of facilitating EIS for individuals diagnosed with HIV infection.

Pursuant to Section 2605(a)(5)
The EMA will participate in an established HIV community based continuum of care, if such continuum exists within the EMA.

Pursuant to Section 2605(a)(6)
Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any state compensation program, insurance policy, or any Federal or state health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

Pursuant to Section 2605(a)(7)(A)
Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

Pursuant to Section 2605(a)(7)(B)
Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

Pursuant to Section 2605(a)(7)(C)
A program of outreach services will be provided to low-income individuals with HIV disease to inform them of the HIV primary medical care and support services.

Pursuant to Section 2605(a)(8)
The EMA has participated in the Statewide Coordinated Statement of Need (SCSN) process initiated by the state, and the services provided under the EMA's comprehensive plan are consistent with the SCSN.

Pursuant to Section 2605(a)(9)
The EMA has procedures in place to ensure that services are provided by appropriate entities.

Pursuant to Section 2605(a)(10)
The EMA will submit audits every 2 years to the lead state agency under Part B of Title XXVI of the PHS Act.

Pursuant to Section 2605(e)
The EMA will comply with the statutory requirements regarding imposition of charges for services.

Pursuant to Section 2681(d)
Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

Pursuant to Section 2684
No funds shall be used to fund AIDS programs, or to develop materials, designed to directly promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual.

Signature Roland Pickens Date 8/8/2018

Attachment 3.

San Francisco EMA FY 2019 Part A Application HIV Epidemiology Summary Table

Group / Exposure Category	New Diagnosed HIV Cases - 1/1/17 - 12/31/17		Persons Living with HIV as of 12/31/17	
	Number	%	Number	%
Total	**325**	**100%**	**15,573**	**100%**
Current gender				
Female	39	12.0%	1,035	6.6%
Male	281	86.5%	14,139	90.8%
Transgender	5	1.5%	399	2.6%
Age group at diagnosis (years)				
0 - 12	0	0.0%	5	0.0%
13 - 24	35	10.8%	151	1.0%
25 - 44	205	63.1%	4,024	25.8%
45 - 64	79	24.3%	9,376	60.2%
65 and Over	6	1.8%	2,017	13.0%
Race / Ethnicity				
Black / African American	44	13.5%	1,933	12.4%
Latino / Hispanic	99	30.5%	3,495	22.4%
Asian / Pacific Islander	48	14.8%	1,100	7.1%
White (not Hispanic)	116	35.7%	8,451	54.3%
Other / Multiethnic / Unknown	18	5.5%	594	3.8%
Transmission category				
Male-to-male sexual contact (MSM)	203	62.5%	11,249	72.2%
Injection drug use (IDU)	29	8.9%	981	6.3%
MSM and IDU	35	10.8%	2,064	13.3%
Heterosexual contact	42	12.9%	1,022	6.6%
Mother with or at Risk for HIV (Pediatric)	0	0.0%	29	0.2%
Unknown risk	16	4.9%	202	1.3%
Other	0	0.0%	26	0.2%

Note: New diagnosed HIV cases include persons living in the SF EMA at time of diagnosis, while persons living with HIV include persons living in the SF EMA as of 12/31/17 regardless of residence at time of diagnosis.

Attachment 4. FY 2019 San Francisco EMA Co-Occurring Conditions Table

Co-Factor / Co-Morbidity	Quantitative Totals	Per Capita Rates	Estimated Costs
Hepatitis C Virus	2015 SF EMA New Reported Chronic Hep C Infections: **2,612** [1] 2015 SF Only New Reported Chronic Hep C Infections: **1,091** 2015 SF Only Total Estimated Persons with Hep C Antibodies: **23,000** [2] 2015 SF Only Total Estimated Persons with Active Hep C Virus: **13,000**	SF EMA-wide: **137.7** per 100,000 SF only: **125.3** per 100,000 SF Persons with Hep C Antibodies: **2,640** per 100,000 SF Persons with Active Hep C Virus: **1,492.7** per 100,000	Estimated annual cost to treat Hepatitis C infection in the SF EMA: **Unknown** [3]
Primary & Secondary Syphilis	2017 SF EMA cases: **628** [4] 2017 SF only cases: **545** 2017 California Cases: **6,672**	SF EMA-wide: **32.1** per 100,000 SF only: **61.9** per 100,000 California: **16.8** per 100,000	Total annual costs related to new STI infections: **$13,896,000** [5] Total annual cost to treat new STI infections among PLWH: **$1,947,500** [6] Estimated cost to treat PLWH each year as a result of transmission facilitated through STIs: **$7,500,000** [7]
Gonorrhea	2017 SF EMA cases: **6,815** 2017 SF only cases: **5,779** 2017 California Cases: **75,372**	SF EMA-wide: **359.4** per 100,000 SF only: **656.4** per 100,000 California: **190.3** per 100,000	
Chlamydia	2017 SF EMA cases: **12,906** 2017 SF only cases: **9,140** 2017 California Cases: **218,728**	SF EMA-wide: **680.5** per 100,000 SF only: **1,038.1** per 100,000 California: **552.2** per 100,000	
Tuberculosis	2017 SF EMA cases: **166** [8] 2017 SF only cases: **107** 2017 California Cases: **2,056**	SF EMA-wide: **8.8** per 100,000 SF only: **12.1** per 100,000 California: **5.2** per 100,000	Estimated annual cost to treat new TB infections: **$830,000** [9] Estimated annual cost to treat new TB infections among PLWH: **$50,000** [10]

Co-Factor / Co-Morbidity	Quantitative Totals	Per Capita Rates	Estimated Costs
Mental Illness	Estimated number of youth and adults with serious mental illness in San Francisco: **44,000** [11] Estimated number of PLWH in SF EMA with serious mental illness: **3,670** [12]	Estimated rate of serious mental illness among PLWH in SF EMA: **23,389** per 100,000 Estimated rate of overall mental health conditions among PLWH in SF EMA: **60,000** per 100,000 [13]	Estimated annual cost of mental health services for PLWH with mental health conditions: **$18,830,000** [14]
Substance Use Disorder	Number of substance-related treatment admissions in SF 2013-2014: **7,940** [15] Estimated number of PLWH in SF EMA with substance-related issues: **6,276** [16]	Annual rate of substance-related SF treatment admissions: **911.7** per 100,000 Estimated rate of substance issues among PLWH in SF EMA: **39,998** per 100,000	Estimated annual cost of substance treatment services for PLWH seeking treatment: **$1,372,500** [17]
Homeless / Unstably Housed	SF Chronic Homeless: Approx. **1,050** [18] SF Temporary / Short-Term Homeless: Approx. **19,497** Per Year [19] Estimated Annual PLWH Homeless in SF EMA: **1,098** [20] Total SF EMA Ryan White Clients Reported as Homeless or Unstably Housed - 3/1/17 - 2/28/18 - **1,994**	Annual SF Homelessness Rate: Approx. **2,238.8** per 100,000 Combined Annual EMA-Wide Homelessness Rate Among PLWH: **7,000** per 100,000 Combined Homeless / Unstably Housed Rate Among All SF EMA Ryan White Clients: **12.8%** [21]	Estimated additional cost of care for HIV-positive homeless persons: Min. **$10,980,000** [22]
Formerly Incarcerated	Average number of unduplicated individuals arrested and incarcerated in the EMA in 2014: **17,500** [23] Number of formerly incarcerated persons in SF EMA Ryan White System, 2013 - 2015: **623** [24]	Annual EMA-wide incarceration rate: **2,815** per 100,000 Three-year PLWH incarceration rate, 2013 -2015: **3,905** per 100,000	Estimated annual cost of care for formerly incarcerated PLWH: **$15,575,000** [25]

[1] All Hepatitis data in this chart: California Department of Public Health Office of Viral Hepatitis Prevention, *California Local Health Jurisdiction Chronic Viral Hepatitis Data Summaries*, Sacramento, CA, November 2016.
[2] Estimates of persons with Hepatitis C in San Francisco from End Hep C SF, *Hepatitis C in San Francisco,* Revised August 2017, http://www.endhepcsf.org/wp-content/uploads/2017/09/SF-HCV-Prevalence-Estimate-Summary_revised-8.17.pdf
[3] Because of the high cost of Hepatitis C treatments, information is still emerging on whether and to what extent health insurance companies will cover the cost of Hepatitis C treatment and what percentage of persons with HIV living with Hepatitis C will opt to access this treatment. At the present time, a 12-week course of Salvadi treatment is $84,000 while a 12-week course of Harvoni treatment is $94,500
[4] All STI data this chart: State of California Department of Health Services, STD Control Branch, Primary and Secondary Syphilis, Gonorrhea, and Chlamydia, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2013-2017 Provisional Data, Sacramento, CA, Revised July 1, 2018.
[5] Calculation based on average of $1,000 per capita for syphilis and gonorrhea treatment combined with cost of undiagnosed and untreated syphilis and gonorrhea (628 and 6,815 new cases, respectively, in 2017) and $500 average per capita for Chlamydia treatment combined with cost of undiagnosed and untreated chlamydia (12,906 new cases in 2016) in the first year following diagnosis.
[6] Calculation based on estimated 5% of persons diagnosed with HIV becoming infected with non-HIV STI annually (n=779) at average treatment cost of $2,500 per capita, including costs of treating negative health consequences of STD among PLWH.
[7] Calculation based on a total of 30 new HIV infections per year facilitated through other STIs at an annual treatment cost of $25,000 x 10 years per person.
[8] All TB data this chart: California Department of Public Health, Tuberculosis Control Branch, Tuberculosis Cases by Year, Reporting Jurisdictions in California, 2008-2017, in Report on Tuberculosis in California, 2017, Sacramento, CA, July 2018.
[9] Calculation based on min. $5,000 treatment cost per year per TB case for 166 new cases in 2017.
[10] Calculation based on min. $5,000 treatment cost per year per TB case for estimated 10 new TB cases among PLWH in 2017.
[11] Source: San Francisco Department of Public Health, Behavioral Health, estimates prepared for FY 2016 San Francisco EMA Ryan White Part A application.
[12] Source: Mayne, T., et al., "Depressive affect and survival among gay and bisexual men infected with HIV," *Archives of Internal Medicine*, 156(19), October 1996.
[13] Estimate of 60% mental health conditions among PLWH in SF EMA includes both serious and persistent mental illness and a range of additional conditions include anxiety and depression.
[14] Calculation based on estimated $2,000 cost for mental health treatment per person x est. 9,415 PLWH in SF EMA with mental health conditions.
[15] Source: Gleghorn A, *Drug Abuse Patterns and Trends in the San Francisco Bay Area – Update: June 2014*, National Institute on Drug Abuse Community Epidemiology Work Group, Washington DC, https://www.drugabuse.gov/sites/default/files/sanfrancisco2014.pdf
[16] Estimate based on conservative estimate of 40% substance use issues among PLWH in SF EMA, including issues with alcohol and marijuana use.
[17] Calculation based on estimated $5,000 cost for substance abuse treatment per person for approximately 25% of PLWH with substance issues who seek treatment annually (n=1,375)
[18] Estimate of chronically homeless based on national estimate of 14% of all homeless being chronically homeless multiplied by total 7,499 homeless individuals identified during the biennial point in time homeless count conducted on January 26, 2017 (7,499 x 14% = 1,050). Sources: National Alliance to End Homelessness, *The State of Homelessness in America 2016*, Washington DC, 2017 and Applied Survey Research, *2017 San Francisco Homeless Count and Survey Comprehensive Report*, San Francisco, CA, 2017.
[19] Estimate of short-term homeless based on national estimate of 86% of all homeless being short-term homeless with average 4-month period of homelessness (7,499 - 1,050 chronic homeless = 6,449 short term homeless x 3 cycles per year = 19,497). Sources: National Alliance to End

Homelessness, *The State of Homelessness in America 2016*, Washington DC, 2017 and Applied Survey Research, *2017 San Francisco Homeless Count and Survey Comprehensive Report*, San Francisco, CA, 2017.

[20] Calculation based on total 15,691 diagnosed persons with HIV living in the EMA with a conservative annual homelessness rate of 7% (n=1,098).

[21] Based on reported 1,994 homeless or unstably housed clients out of total 7,224 Ryan White clients in the SF EMA from March 1, 2017 - February 21, 2018.

[22] Calculation based on total 15,691 persons with HIV living in the EMA with a conservative annual homelessness rate of 7% (n=1,098) and a minimum additional cost of $10,000 to meet these individuals' annual homeless-related needs.

[23] Based on total reported jail bookings in Marin, San Francisco, and San Mateo Counties in 2014with an estimated recidivism rate of 50%.

[24] Based on service data from Forensic AIDS Project, the San Francisco EMA Center of Excellence serving formerly incarcerated PLWH.

[25] Calculation based on estimated cost of $25,000 per year to provide care for the minimum 623 formerly incarcerated persons in the SF EMA Ryan White system of care.

Attachment 5. FY 2019 San Francisco EMA Coordination of Services and Funding Table

Funding Source	2018 Budget	**Core Medical Services**	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-	Home Health Care	Home & Community-based Health	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services –	**Supportive Services**	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Facility-Based Health Care	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive	Rehabilitation Services	Respite Care	Substance Abuse Services –	Treatment Adherence Counseling	**HIV Prevention**	HIV Testing	PrEP & PEP Services	Other Prevention Services
Part A	**$ 14,745,389**		X		X	X	X		X	X	X	X		X			X		X	X	X		X	X		X	X	X								
Part B	**$ 3,381,304**		X								X										X	X						X								
Part C	**$ 1,132,864**		X											X			X											X								
Part D	**$ 514,799**		X											X																						
Part F	**$ 600,000**					X																														
CDC	**$ 6,409,245**																										X						X		X	X	
HOPWA	**$ 712,763**																						X														
MEDICAID (Estimated)	**$ 60,909,907**		X	X	X	X			X		X	X		X	X																						

San Francisco HIV Community Planning Council

San Francisco Eligible Metropolitan Area
San Francisco, San Mateo, and Marin Counties

August 20, 2018

Steven R. Young, MSPH
Director, Division of Metropolitan HIV/AIDS Programs
HIV/AIDS Bureau, Health Resources and Services Administration
Parklawn Building, Room 7A-55, 5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Young:

As Co-Chairs of the San Francisco HIV Community Planning Council, and on behalf of the Planning Council as a whole, we are writing to provide assurance of the following procedural elements related to the FY 2019 Ryan White Part A application submitted to HRSA by the San Francisco Department of Public Health:

- No FY 2018 Conditions of Award were related to the Planning Council and its activities, and therefore all FY 2018 Conditions of Award related to the Planning Council have been addressed.
- The Planning Council continually tracks the allocation and expenditure of Part A Formula, Supplemental, and MAI funds by the San Francisco Department of Public Health, and ensures that FY 2018 Part A funds awarded to the EMA are being expended according to the priorities established by the Planning Council.
- The Planning Council utilizes a collaborative planning process that incorporates a wide range of relevant data and consumer and provider input to determine FY 2019 Part A funding priorities, and to establish priorities through an open voting process.
- The most recent training for new Planning Council members took place on February 22, 2018 while the most recent annual Planning Council training took place on October 3, 2017. The next annual Planning Council training will take place on September 21, 2018.

Thank you for your continuing support of the San Francisco region and its merged HIV Community Planning Council. We look forward to continuing our efforts to provide effective, comprehensive, and high-quality services to low-income and severely impacted persons living with HIV in our region.

Sincerely,

David Gonzalez
Community Co-Chair

Mike Shriver
Community Co-Chair

Linda Walubengo
Community Co-Chair

Attachment 7. San Francisco, California EMA FY 2019 HIV Care Continuum Table
Baseline Reporting Period: January 1 - December 31, 2017

Stages of the HIV Care Continuum	HIV Care Continuum Goal	Outcomes		Applicable Part A Funded Service Categories
I. Diagnosed	Increase in the percentage of clients who are aware of their HIV status as a percentage of all PLWH in the San Francisco EMA	HIV Positivity & Late HIV Diagnosis		▪ Early Intervention Services ▪ Outreach Services
		Baseline: **15,252 / 15,862 - 96.0%**	**FY 2019 Target:** **15,421 / 15,898 - 97.0%**	
II. Linked to Care	Increase in the percentage of clients linked to care among those newly testing positive within the reporting period	Linkage to HIV Medical Care		▪ Outpatient Medical Care ▪ Early Intervention Services ▪ Medical Case Management ▪ Non-Medical Case Mgmt. ▪ Medical Transportation
		Baseline: **286 / 325 - 88.0%**	**FY 2019 Target:** **293 / 325 - 90.0%**	
III. Retained in Care	Increase in the percentage of clients retained in care among all PLWH in the San Francisco EMA	Retention in HIV Medical Care, Defined as at Least 2 Visits at Least 3 Months Apart in a CY		▪ Outpatient Medical Care ▪ Early Intervention Services ▪ Medical Case Management ▪ Medical Transportation ▪ Mental Health Services
		Baseline: **8,907 / 15,252 - 58.4%**	**FY 2019 Target:** **9,539 / 15,898 - 60.0%**	
IV. Prescribed ART	Increase in the percentage of clients with access to prescribed HIV/AIDS medications among all PLWH in the San Francisco EMA	Antiretroviral Therapy (ART) Among Persons in HIV Medical Care & Prescription of HIV Antiretroviral Therapy		▪ Outpatient Medical Care ▪ Pharmaceutical Assistance ▪ Medical Case Management ▪ Medical Transportation
		Estimated Baseline: **11,790 / 15,252 -77.3%**	**FY 2019 Target:** **12,718 / 15,898 - 80%**	
V. Virally Suppressed	Increase in the percentage of clients with a viral load of <200 among all PLWH in the San Francisco EMA	Viral Load Suppression Among Persons in HIV Medical Care & HIV Viral Load Suppression		▪ Outpatient Medical Care ▪ Pharmaceutical Assistance ▪ Medical Case Management ▪ Medical Transportation ▪ Treatment Adherence
		Baseline: **11,012 / 15,252 -72.2%**	**FY 2019 Target:** **11,765 / 15,898 - 74%**	

Attachment 8: FY 2019 Service Category Plan Tables

Service Category Plan Table # 1: Non-MAI Part A Funding

Service Category	Priority #	FY 2018 As Submitted With Prior Part A Application				FY 2019 Anticipated			
		Allocated Funding Amount	UDC Served	Service Unit Def.	Service Units	Allocated Funding Amount	UDC Served	Service Unit Def.	Service Units
Outpatient/ Ambulatory Health Services	2018: 2-3 2019: 3	$2,678,155	3,032	1 unit = 1 visit	49,706	$1,120,934	1,269	1 unit = 1 visit	20,804
Medical Case Management, including Treatment Adherence	2018: 4 2019: 4	$1,868,279	487	1 unit = 1 hour	48,251	$3,332,272	869	1 unit = 1 hour	86,061
Hospice Services	2018: 8 2019: 9	$784,687	43	1 unit = beds x days	11,452	$823,921	45	1 unit = beds x days	12,025
Mental Health Services	2018: 1 2019: 1	$1,742,566	2,753	1 unit = 1 hour	24,774	$1,851,019	2,924	1 unit = 1 hour	26,316
Oral Health Care	2018: 5 2019: 5	$806,269	1,312	1 unit = 1 visit	7,167	$846,582	1,378	1 unit = 1 visit	7,525
Health Insurance Premium & Cost Sharing Assistance	2018: NA 2019: NA	$40,000	47	1 unit = 1 request	123	$43,253	51	1 unit = 1 request	133
Early Intervention Services	2018: 10 2019: 11	$31,461	113	1 unit = 1 test	871	$33,034	119	1 unit = 1 test	915
Substance Abuse Services - Outpatient	2018: NA 2019: 10					$91,117	168	1 unit = 1 SA assess-ment or treat-ment session	1,035

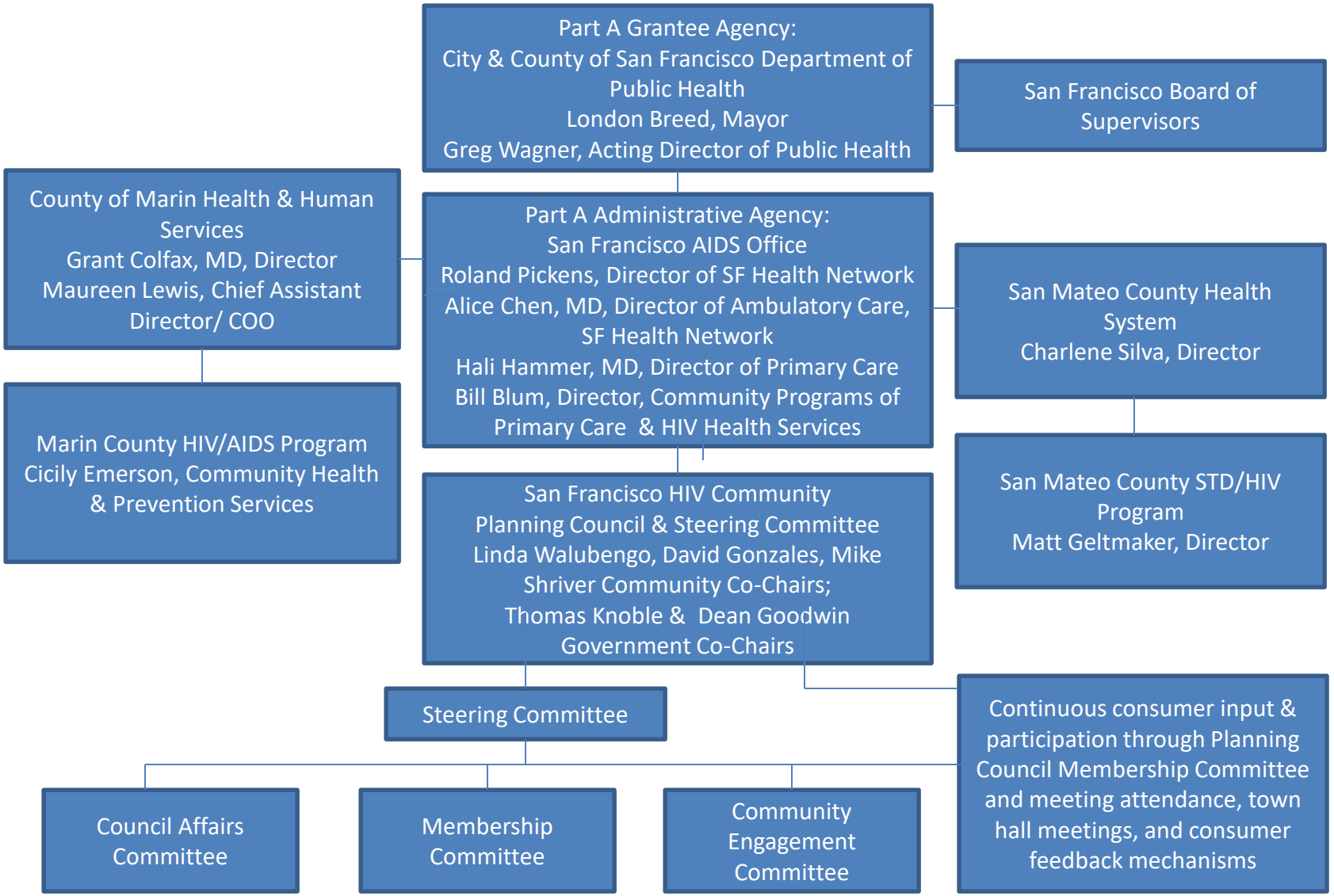
Service Category	Priority #	FY 2018 As Submitted With Prior Part A Application				FY 2019 Anticipated			
		Allocated Funding Amount	UDC Served	Service Unit Def.	Service Units	Allocated Funding Amount	UDC Served	Service Unit Def.	Service Units
Home Health Care	2018: 9 2019: 8	$271,003	68	1 unit = 2 hours atten-dant care, 1 unit = 2 hours home-maker service	3,025	$284,553	71	1 unit = 2 hours atten-dant care, 1 unit = 2 hours home-maker service	3,176
Housing Services	2018: 1-2, 5, 7, 10 2019: 1-2, 5, 7, 12	$890,732	202	Varies	9,223	$961,912	218	Varies	9,960
Emergency Financial Assistance	2018: 4 2019: 4	$1,102,597	1,503	1 unit = 1 request	3,732	$1,151,892	1,570	1 unit = 1 request	3,899
Non-Medical Case Management	2018: 8 2019: 6	$1,951,844	934	1 unit = 1 visit	29,605	$2,051,813	982	1 unit = 1 visit	31,121
Food Bank / Home-Delivered Meals	2018: 3 2019: 3	$120,000	561	1 unit = 1 lb. food, 1 unit = 1 pre-pared meal, 1 unit = 1 provi-ded grocery	491,100	$127,603	597	1 unit = 1 lb. food, 1 unit = 1 pre-pared meal, 1 unit = 1 provi-ded grocer	522,215
Other Professional Services (Legal)	2018: 9 2019: 9	$284,620	350	1 unit = 1 hour of legal service	4,476	$298,851	368	1 unit = 1 hour of legal service	4,700
Outreach Services	2018: 12 2019: 13	$267,677	560	1 unit = 1 hour	3,408	$281,061	588	1 unit = 1 hour	3,578
Medical Transpor-tation	2018: 14 2019: 15	$14,000	147	1 unit = 1 ride	395	$19,461	204	1 unit = 1 ride	549

Service Category	Priority #	FY 2018 As Submitted With Prior Part A Application				FY 2019 Anticipated			
		Allocated Funding Amount	UDC Served	Service Unit Def.	Service Units	Allocated Funding Amount	UDC Served	Service Unit Def.	Service Units
Psychosocial Support Services	2018: 6 2019: 7	$474,972	486	1 unit = 1 hour	13,395	$500,249	512	1 unit = 1 hour	14,108

Service Category Plan Table # 2: MAI Part A Funding

Service Category	Priority #	FY 2018 As Submitted With Prior Part A Application				FY 2019 Anticipated			
		Allocated Funding Amount	UDC Served	Service Unit Definition	Service Units	Allocated Funding Amount	UDC Served	Service Unit Definition	Service Units
Outpatient/ Ambulatory Health Services	2018: NA 2019: NA	$497,634	100	1 unit = 1 visit	6,536	$15,364	3	1 unit = 1 visit	202
Medical Case Management	2018: NA 2019: NA	$193,747	178	1 unit = 1 hour	5,004	$476,681	438	1 unit = 1 hour	12,311
Mental Health Services	2018: NA 2019: NA					$140,492	222	1 unit = 1 hour	1,997
Substance Abuse Services - Outpatient	2018: NA 2019: NA					$92,511	50	1 unit = 1 SA assessment or treatment session	1,022

Attachment 10. FY 2019 San Francisco, California Eligible Metropolitan Area
EMA Organizational Chart



ATTACHMENT 11. FY 2019 MAINTENANCE OF EFFORT DOCUMENTATION

NON-FEDERAL EXPENDITURES

FY Prior to Application (Actual)	Current FY of Application (Estimated)
Actual prior FY non-federal EMA political subdivision expenditures for HIV-related core medical and support services **Amount: $ 15,203,298**	Estimated current FY non-federal EMA political subdivision expenditures for HIV-related core medical and support services **Amount: $ 15,204,031**

The San Francisco EMA is fully committed to continuing to contribute ongoing, significant resources to augment and maximize contributions made to our region through the Ryan White Care Act, utilizing a diverse range of expense fields to track and monitor maintenance of effort expenditures, as described in the table below. The table below summarizes a total of **$15,203,298** in identified non-federal EMA political subdivision expenditures for HIV core medical and support services in the 2017-2018 Fiscal Year, including expenditures for core and non-core Part A services and expenditures that incorporate all three counties of the San Francisco EMA. Utilizing a cross-service approach provides a reliable indicator of continuing support for HIV/AIDS services throughout the region. Despite the wealth of resources described, the chart below does not include all local HIV expenditures, since many services to persons with HIV are not tracked in specific relation to HIV diagnosis. The San Francisco EMA will continue its efforts to make significant and meaningful financial contributions that increase the value and impact of all Ryan White funding streams.

SF EMA MAINTENANCE OF EFFORT REPORTING CATEGORIES	Actual FY 2017	Anticipated FY 2018
CORE MEDICAL SERVICES		
AMBULATORY / OUTPATIENT MEDICAL CARE		
▪ **San Francisco General Hospital (SFGH)/ Other SF DPH Outpatient Medical Care/ SF DPH Jail Health:** Total charges from the Invision billing data base for ambulatory services with primary and secondary diagnosis of HIV (042) by financial class, based on hospital's cost to charge ratio for unreimbursed financial classes and total charges for ambulatory services from local General Funds.	**$5,265,406**	**$5,394,015**

SF EMA MAINTENANCE OF EFFORT REPORTING CATEGORIES	Actual FY 2017	Anticipated FY 2018
▪ **Marin HIV/ AIDS Integrated Clinics:** Total charges for ambulatory services from local General Funds spent on program expenses over and above costs of direct core medical service and support services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$195,461**	**$0**
▪ **San Mateo County Primary Medical Care:** Total charges for ambulatory services from local General Funds spent on program expenses over and above costs of direct core medical service and support services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$391,175**	**$388,517**
MENTAL HEALTH SERVICES		
▪ **San Francisco County:** Total charges for mental health services from local General Funds spent on program expenses over and above costs of mental health services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$285,570**	**$296,180**
▪ **San Mateo County:** Total charges for mental health services from local General Funds spent on program expenses over and above costs of mental health services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$10,306**	**$16,007**
MEDICAL CASE MANAGEMENT SERVICES		
▪ **Marin County:** Total charges for medical case management services from local General Funds spent on program expenses over and above costs of medical case management services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$151,000**	**$141,380**
▪ **San Mateo County:** Total charges for medical case management services from local General Funds spent on program expenses over and above costs of medical case management services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$19,540**	**$16,497**
HOME HEALTH CARE SERVICES		
▪ **San Francisco County**: Total charges for home health care services from local General Funds spent on program expenses over and above costs of home health care services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$173,008**	**$208,841**

SF EMA MAINTENANCE OF EFFORT REPORTING CATEGORIES	Actual FY 2017	Anticipated FY 2018
SUPPORT SERVICES		
RESIDENTIAL SUBSTANCE ABUSE SERVICES		
▪ **San Francisco County:** Total charges for residential substance abuse services from local General Funds spent on program expenses over and above costs of residential substance abuse services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$1,355,929**	**1,389,828**
NON-MEDICAL CASE MANAGEMENT SERVICES		
▪ **San Francisco County:** Total charges for referral for Non-Medical Case Management (Benefits Counseling and Referrals) from local General Funds spent on program expenses over and above costs of health care and supportive services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$254,074**	**$260,425**
▪ **San Francisco County:** Total charges for non-medical case management (benefits counseling) services from local General Funds spent on program expenses over and above costs of medical case management services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$233,076**	**$238,903**
▪ **San Francisco County:** Total charges for non-medical case management (employment training and readiness services) services from local General Funds spent on a program expenses over and above costs of mental health services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$142,020**	**$145,590**
HOUSING SERVICES		
▪ **San Francisco County:** Total charges for housing services from local General Funds spent on a program expenses over and above costs of housing services to Ryan White eligible clients not otherwise funded by separate program agreements and/or outside revenue.	**$6,726,733**	**$6,707,848**
TOTAL MAINTENANCE OF EFFORT	**$ 15,203,298**	**$15,204,031**

GRANT AGREEMENT

between

CITY AND COUNTY OF SAN FRANCISCO

and

COUNTY OF SAN MATEO

THIS GRANT AGREEMENT (this "Agreement") is made this **MARCH 1ST, 2016** , in the City and County of San Francisco, State of California, by and between **THE COUNTY OF SAN MATEO** ("Grantee") and the **CITY AND COUNTY OF SAN FRANCISCO**, a municipal corporation ("City") acting by and through the Agency (as hereinafter defined),

WITNESSETH:

WHEREAS, Grantee has submitted to the Agency the Application Documents (as hereinafter defined) seeking a Ryan White Comprehensive AIDS Resource Emergency Act of 1990 (hereafter, "CARE Act") grant for the purpose of funding the matters set forth in the Grant Plan (as hereinafter defined); and summarized briefly as follows:

to provide emergency assistance to eligible metropolitan areas that are disproportionately affected by the Human Immunodeficiency Virus epidemic and to make financial assistance available to States and other public or private nonprofit entities to provide for the development, organization, coordination and operation of more effective and cost efficient systems for the delivery of essential services to individuals and families with HIV disease.

WHEREAS, City desires to provide such a grant on the terms and conditions set forth herein:

NOW, THEREFORE, in consideration of the premises and the mutual covenants contained in this Agreement and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties hereto agree as follows:

ARTICLE 1
DEFINITIONS

1.1 Specific Terms. Unless the context otherwise requires, the following capitalized terms (whether singular or plural) shall have the meanings set forth below:

(a) "**ADA**" shall mean the Americans with Disabilities Act (including all rules and regulations thereunder) and all other applicable federal, state and local disability rights legislation, as the same may be amended, modified or supplemented from time to time.

(b) "**Agency**" shall mean **CITY AND COUNTY OF SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH**.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed as of the date first specified herein.

CITY

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

By: _____
Barbara A. Garcia, M. P. A
Director, Department of Health

Approved as to Form:

Dennis J. Herrera
City Attorney

By: _____ 1/24/17
Deputy City Attorney

GRANTEE:

By signing this Agreement, I certify that I comply with the requirements of the Minimum Compensation Ordinance, which entitle Covered Employees to certain minimum hourly wages and compensated and uncompensated time off.

I have read and understood paragraph 16.3, the City's statement urging companies doing business in Northern Ireland to move towards resolving employment inequities, encouraging compliance with the MacBride Principles, and urging San Francisco companies to do business with corporations that abide by the MacBride Principles.

COUNTY OF SAN MATEO

By: Don Horsley

Print Name: Don Horsley

Title:
President, Board of Supervisors

Federal Tax ID #: 94-6000532

City Vendor Number: 16419

ATTEST:

By: _____
Clerk of Said Board

GRANT AGREEMENT

between

CITY AND COUNTY OF SAN FRANCISCO

and

COUNTY OF MARIN

THIS GRANT AGREEMENT (this "Agreement") is made this **MARCH 1ST, 2016** , in the City and County of San Francisco, State of California, by and between **THE COUNTY OF MARIN** ("Grantee") and the **CITY AND COUNTY OF SAN FRANCISCO**, a municipal corporation ("City") acting by and through the Agency (as hereinafter defined),

WITNESSETH:

WHEREAS, Grantee has submitted to the Agency the Application Documents (as hereinafter defined) seeking a Ryan White Comprehensive AIDS Resource Emergency Act of 1990 (hereafter, "CARE Act") grant for the purpose of funding the matters set forth in the Grant Plan (as hereinafter defined); and summarized briefly as follows:

to provide emergency assistance to eligible metropolitan areas that are disproportionately affected by the Human Immunodeficiency Virus epidemic and to make financial assistance available to States and other public or private nonprofit entities to provide for the development, organization, coordination and operation of more effective and cost efficient systems for the delivery of essential services to individuals and families with HIV disease.

WHEREAS, City desires to provide such a grant on the terms and conditions set forth herein:

NOW, THEREFORE, in consideration of the premises and the mutual covenants contained in this Agreement and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties hereto agree as follows:

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(b) "**Agency**" shall mean **CITY AND COUNTY OF SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH**.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed as of the date first specified herein.

CITY

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUCLIC HEALTH

By: 12/12/16
Barbara A. Garcia, M. P. A
Director, Department of Health

GRANTEE:

By signing this Agreement, I certify that I comply with the requirements of the Minimum Compensation Ordinance, which entitle Covered Employees to certain minimum hourly wages and compensated and uncompensated time off.

I have read and understood paragraph 16.3, the City's statement urging companies doing business in Northern Ireland to move towards resolving employment inequities, encouraging compliance with the MacBride Principles, and urging San Francisco companies to do business with corporations that abide by the MacBride Principles.

COUNTY OF MARIN

By: Steve Kinsey

Print Name: Steve Kinsey

Title:
President, Marin County Board of Supervisors

Federal Tax ID #: 94-6000519

City Vendor Number: 34057

Approved as to Form:

Dennis J. Herrera
City Attorney

By: 12/9/16
Deputy City Attorney

Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: San Francisco Dept of Public Health

DUNS Number: 1037173360000

* Street1: 25 Van Ness Ave, 8th Fl

Street2:

* City: San Francisco

County:

* State: CA: California

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 94102-6012

* Project/ Performance Site Congressional District: ca-012

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code:

* Project/ Performance Site Congressional District:

Additional Location(s)

Add Attachment | Delete Attachment | View Attachment

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** Project Narrative.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

BUILDING A MODEL FOR ENDING HIV:
SAN FRANCISCO EMA FY 2019 RYAN WHITE PART A
COMPETING CONTINUATION APPLICATION NARRATIVE

INTRODUCTION

The San Francisco Eligible Metropolitan Area (EMA) requests a total **$16,202,223** in Fiscal Year 2019 Ryan White Part A Formula and Supplemental funding to continue to meet the ongoing local crisis of HIV infection and to continue to develop innovative, effective, and collaborative models for linking and retaining persons in HIV care and achieving the maximum possible levels of viral load suppression in our region. 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 2019 Part A Service Plan outlined 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 (PLWH). 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 2019 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, creating challenges for those attempting to move between the county's eastern and western sides. The San Francisco (SF) EMA is also unusual because of the dramatic difference in the size of its member counties. While Marin and San Mateo Counties have a land area of **520** and **449** square miles, respectively, San Francisco County has a land area of only **46.7** square miles, making it **by far the smallest county in California** geographically, and the **sixth smallest**

county in the US in terms of land area. San Francisco is also one of only three major cities in the US (the others are Denver and Washington, DC) in which the city's borders are identical to those of the county in which it is located. The unification of city and county governments under a single mayor and Board of Supervisors allows for a streamlined service planning and delivery process.

According to the US Census, as of July 1, 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 neighboring 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:

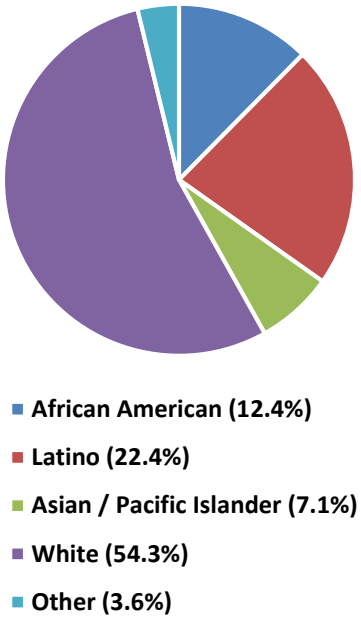
i. Demographic Data: More than 35 years into the HIV epidemic, the three counties of the San Francisco region continue to be devastated by HIV – an ongoing crisis that has exacted an enormous human and financial toll on our region. As of December 31, 2017, over **42,000** cumulative cases of HIV had 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 **15,573** persons were currently living with HIV in the region's three counties, representing **12%** of Californians living with HIV and **2%** of all persons living with HIV in the US. The SF EMA's region-wide HIV infection rate of **821.2** cases per 100,000 persons also means that roughly **1 in every 120 residents of the San Francisco region is now living with HIV.** This figure of 15,573 living HIV cases represents the most up-to-date data provided from the State of California, and is based strictly on the number of persons living with HIV who

have a **current address** in the San Francisco EMA. Several thousand more living cases of HIV have been diagnosed in the San Francisco EMA, but are not included in our proposal in order to be as accurate as possible regarding the current state of local HIV care needs.

At the epicenter of the continuing HIV 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 2017, a total of **13,102** San Franciscans were living with diagnosed HIV infection, representing **84.1%** of all persons living with HIV in the three-county region, for a staggering citywide prevalence of **1,504.4 cases of HIV per 100,000.** A total of at least **221** new cases of HIV infection were diagnosed in San Francisco in calendar year 2017 alone.

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 are white (**54.3%**). Another **12.4%** of cases are among African Americans; **22.4%** are among Latinos; and **7.1%** are among Asian / Pacific Islanders (see **Figure 1**). A total of **7,122** persons of color were living with HIV infection in the three-county region as of December 31, 2017, representing **45.7%** of all persons living with HIV. African Americans are significantly over-represented in terms of HIV infection, making up **12.4%** 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 **37.2%** 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 trans PLWH, including a population that is **32.6%** African American, **33.9%** Latina, and **10.2%** Asian / Pacific Islander.

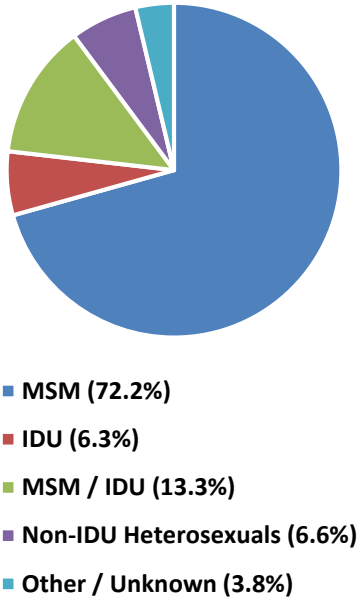
Figure 1. Persons Living with HIV in San Francisco EMA by Ethnicity as of December 31, 2017



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, 2017, fully **85.5%** of persons

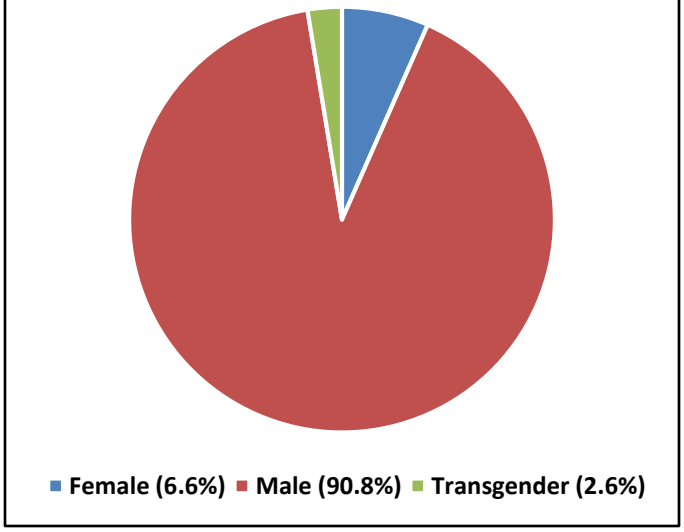
living with HIV in our region were MSM (**13,313**), including **11,249** men infected with HIV through MSM contact only (**72.2%** of all PLWH) and **2,064** MSM who also injected drugs (**13.3%** of all PLWH) (see **Figure 2**). This actually represents an **increase** from a decade ago, in 2008, when MSM made up **82.3%** of all PLWH. By comparison, only **42.0%** of all PLWH in New York City as of December 31, 2016 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) (**6.3%** of PLWH) and non-PIWD heterosexuals (**6.6%**). The proportion of heterosexual HIV cases in the San Francisco EMA is believed to be the lowest of any EMA in the US.

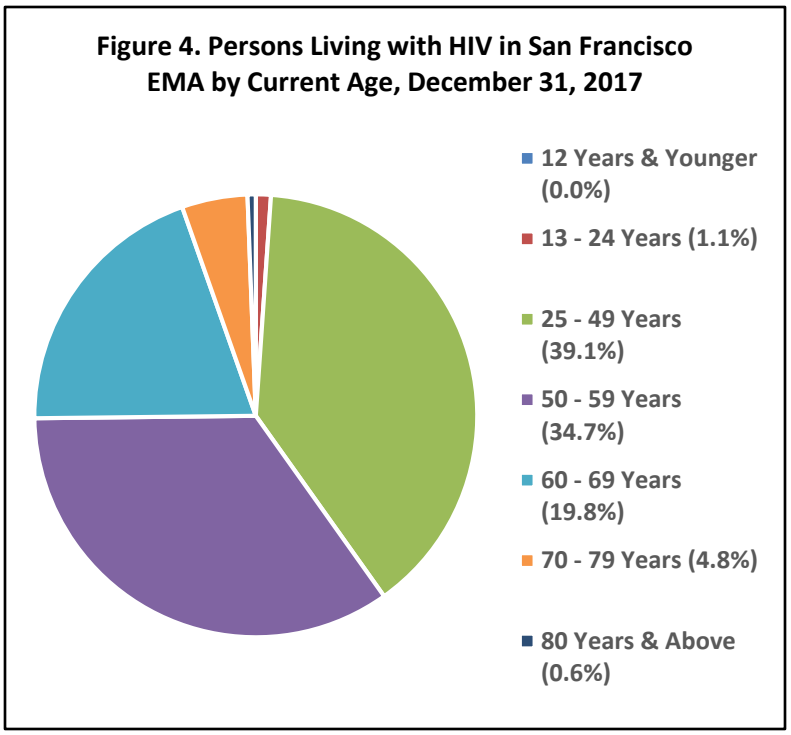
Figure 2. Persons Living with HIV in San Francisco EMA by Transmission Category as of December 31, 2017



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 cis men (see **Figure 3**). Only **6.6%** of PLWH in the region are cis women, over **71%** 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 **399** transgender individuals - the vast majority of them male-to-female – living with HIV as of December 31, 2017, representing **2.6%** of the region's PLWH caseload.

Figure 3. Persons Living with HIV in San Francisco EMA by Gender as of December 31, 2017





Current Age: The growing 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 - and to the region's hard-fought success in bringing persons with HIV into care and maintaining their health over time. As of December 31, 2017, **exactly 3 out of every 5** persons living with HIV in the SF EMA (**60.0%**) is age 50 or older, including **5,418** PLWH between the ages of 50 and 59; **3,078** PLWH between the ages of 60 and 69; **740** PLWH between the ages of 70 and 79; and **90** PLWH who are age 80 or older (see **Figure 4**). In the city of San Francisco, persons 50 and older make up **65%** of all persons living with HIV. Between December 2009 and December 2017, the number of persons 50 and over living with HIV increased by **43%** within the region while the number of PLWH 65 and older increased by **91.2% 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.

In terms of other age groups, persons between the ages of 25 and 49 make up **39.1%** of all PLWH in the region (n=**6,091**) while young adults ages 13 - 24 make up **1.1%** of all PLWH in the region (n=**151**). However, young people ages 13 - 24 made up fully **10.8%** of all new HIV cases identified in calendar year 2017 alone, pointing to a growing HIV incidence within this population. The population of young PLWH also includes a significantly higher percentage of **persons of color**, who make up **72.2%** of young people with HIV ages 13 - 24 as compared to **45.7%** of the overall PLWH population. The same is true for **cis women**, who make up **19.9%** of youth PLWH as compared to only **6.6%** of all PLWH in the EMA. Only **5** children age 12 and under are living with HIV in the region, and **no** new HIV cases have been diagnosed among this group between January 1, 2010 and December 31, 2017.

ii) Socioeconomic Data:

Poverty: 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 **60.6%** of all persons living with HIV in the San Francisco region (n=**9,434**) are living at or below 300% of the 2018 Federal Poverty Level (FPL) including persons in impoverished households, while **99.0%** of Part A-funded clients live at or below 400% of poverty.[5] ARIES data also reveals that **73.8%** of active Ryan White Part A clients in the San Francisco region are currently living at or below 138% of FPL while another **15.1%** are living between 139% and 250% of FPL. HIV-infected persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **$236 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 factor in ensuring 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, 2018

County	Hourly Wage to Rent a 2-Bdrm. Apt. at HUD Fair Market Rents
San Francisco County, CA	$ 60.02
Marin County, CA	$ 60.02
San Mateo County, CA	$ 60.02
Santa Clara County, CA	$ 48.50
Alameda County, CA	$ 44.79
Contra Costa County, CA	$ 44.79
Honolulu County, HI	$ 39.06
Santa Cruz County, CA	$ 37.79
Santa Barbara County, CA	$ 36.87
Nassau County, NY	$ 36.12

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 2018* 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 **$60.02 per hour** (see **Figure 5**).[8] This means that an individual must make at least $60 an hour to afford a 2-bedroom apartment, and represents an increase of **36.3% in the last 24 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]

At the same time, San Francisco has the **second highest** per capita homelessness rate of any city in the U.S. and one of the largest proportions of unsheltered homeless, at **88.2%**, with more than 3**,000** children homeless in SF at any given time - an alarming **94% increase** over 2007 levels.[10] Just under **5%** of SF public school students experienced homelessness in 2014, as compared to a national average of less than **3%,**[11] while nearly **half** of all homeless families in SF report having experienced domestic abuse.[12] These impacts are amplified by the **growing disparity between rich and poor in San Francisco.** According to the Brookings Institution, between 2007 and 2012 alone, the gap between the average household income of poor residents and wealthy ones grew **more in SF than in any other city in the United States**.[13] More than **59%** of single parents in SF live below the **California Self-Sufficiency Standard (SSS)**, a measure that incorporates the cost of basic needs for California's working families. An analysis of 2017-2018 ARIES data revealed that only about **two-thirds** Ryan White Part A clients were stably housed during the year (**67.1%**), with **22.3%** living in temporary housing and **5.3%** living in unstable housing, including in shelters and on the street.

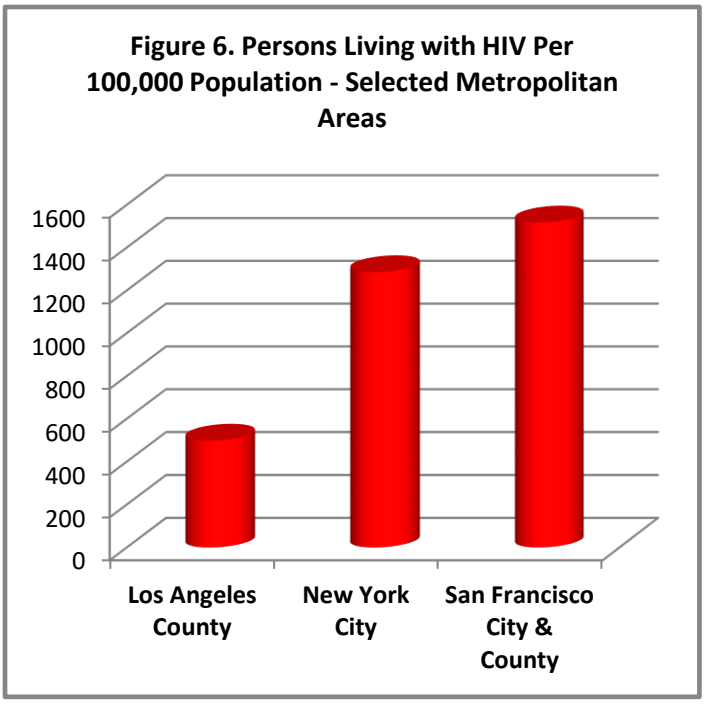
Insurance Coverage: The advent of health care reform through the Affordable Care Act (ACA) has resulted in significant, positive change in regard to the number and proportion of low-income persons with HIV in our region who benefit from affordable and more accessible health insurance coverage. According 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.[14] Nevertheless, significant insurance gaps continue to remain in our region. Analysis of local ARIES data revealed that **28.4%** of all persons enrolled in Ryan White Part A services in the three-county regions during the 2017-2018 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 Asian / Pacific Islanders) 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 50 years and older increases and as these individuals 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.

Burden of HIV in the Service Area: 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 2017, a total of **13,102** San Franciscans were living with diagnosed HIV, representing **84.1%** 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 **1,504.4** 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**).[15]



c. New HIV Infections:

i. Trends in New HIV Infections: 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 **325** new cases of HIV infection diagnosed in the SF EMA in calendar year 2017 is the fewest number of regional new infections in the history of the HIV epidemic, while the **221** new HIV cases diagnosed in San Francisco represents a **16% reduction** over the past two years, and a **49% reduction** over the past five years. Between 2006 and 2017, the number of newly identified HIV infections among whites in San Francisco declined by **241%**, from **290** to **85** new cases, while the number of newly identified cases among African Americans declined by **108%,** from **77** in 2006 to **37** in 2017. The rate of new HIV diagnoses among Latino men in SF also dropped from **116** in 2016 to **55** in 2017, a reduction of **111%**. At the same time, however, per capita rates of new HIV diagnoses among SF women remained relatively consisted over this time period,

with rates of new HIV diagnoses among African American women dropping only slightly, from **47** new infections per 100,000 in 2016 to **43** infections per 100,000 in 2017. Similarly, rates of new HIV infection for Latina women declined from **11** per 100,000 to **9** per 100,000, while rates among white women dropped from **9** per 100,000 to **5** per 100,000.

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 HIV 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, **94%** of people living with HIV in San Francisco are estimated to be **aware of their infection.**

- The proportion of **late diagnoses** (progressing to AIDS within 3 months of HIV diagnosis) declined from **18%** in 2013 to **11%** in 2016. Nationally the proportion of late testers is **21%.**

- Only **6%** of people living with HIV are **persons who inject drugs (PWID)** and **11%** 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, **83%** 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 **85%** in 2016.

- **Time to ART (Antiretroviral Therapy) initiation** after HIV diagnosis has improved from a median time (when 50% initiated ART) of **3** months in 2011 to less than **1** month in 2016.

- **Time to viral suppression** after HIV diagnosis has improved, with median time to viral suppression increasing from **6** months in 2011 to **2** months in 2016.[16]

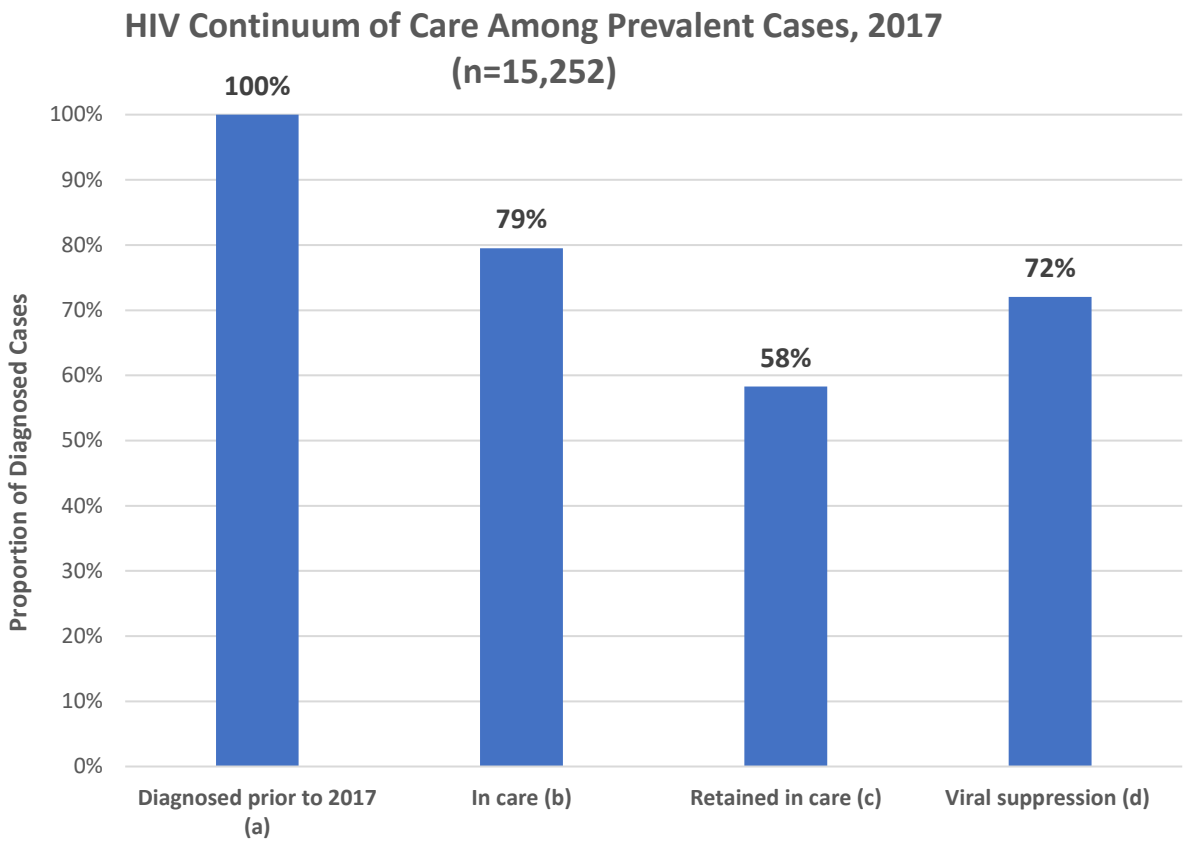
ii. <u>Increasing Need for HIV Services:</u> While the successes of the San Francisco approach to HIV prevention, identification, and care are both significant and heartening, it is critical to note that a large share of the model's success is attributable to the **significant**

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.

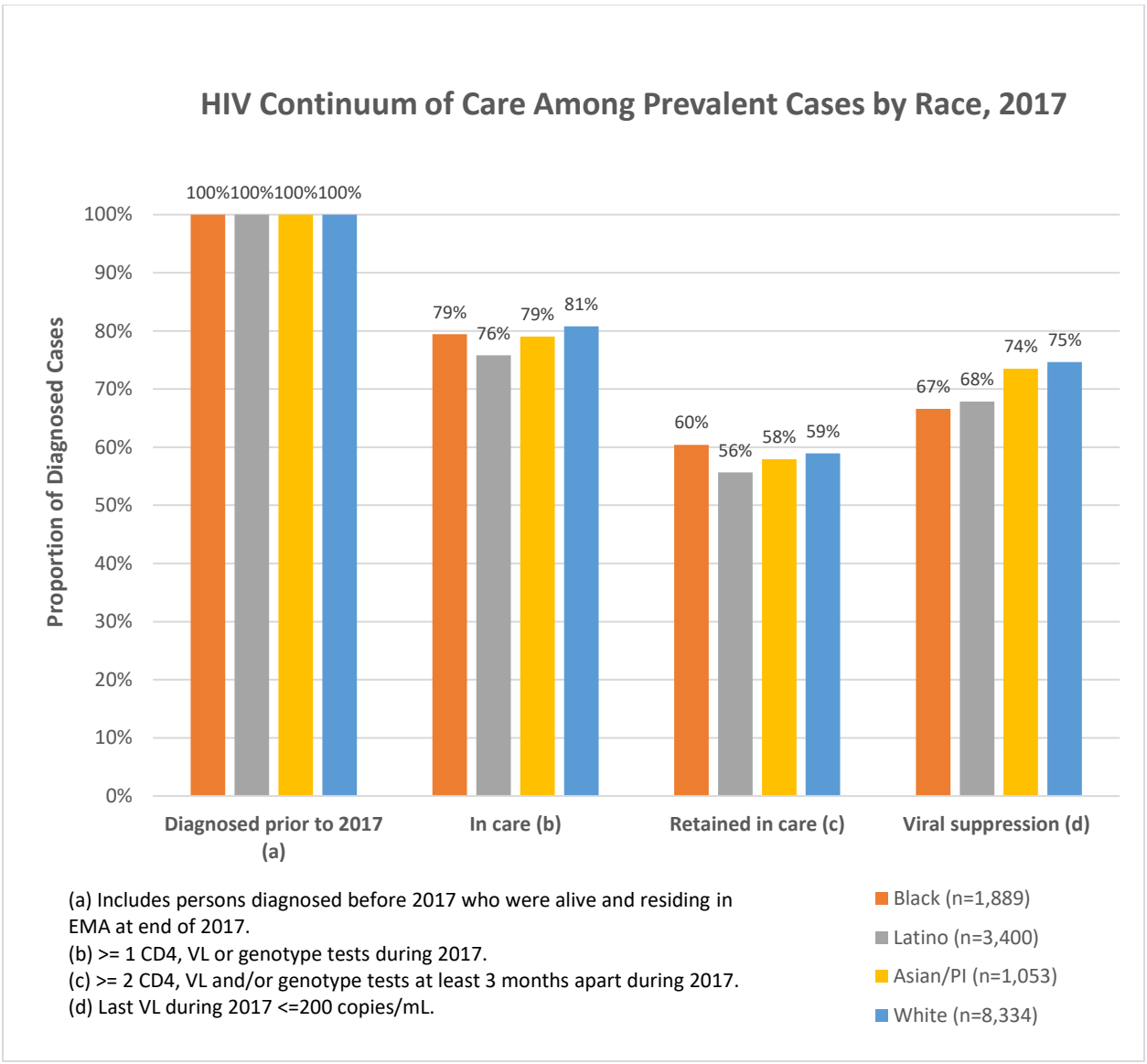
2. HIV Care Continuum

The chart on the following pages depicts the HIV care continuum for the San Francisco EMA for calendar year 2017. As noted on the table, the EMA has achieved remarkable success in linking and retaining persons in care and in achieving viral suppression across the region. A total of **79%** of all persons with a confirmed HIV diagnosis currently living in the EMA are engaged in care, defined as at least 1 CD4, viral load, or HIV genotype test during calendar year 2017, while fully **72%** of have achieved viral load suppression, defined as less than 200 copies per ml. at the time of the most recent viral load test. Additionally, **58%** of SF EMA PLWH were retained in care in 2017 based on a definition of at least two reportable HIV-related lab tests at least 3 months apart. The lower percentage of persons retained in care using this definition is believed to be largely based on a growing standard in which long-term survivors with HIV whose health condition has been stable for many years of decades are being seen **annually** by physicians, with additional office visits made only to treat specific conditions or symptoms. The significantly higher percentage of persons with viral suppression compared to the number of persons with 2 or more medical visits in a year may speak to the success of this overall approach, although more information is needed to verify this.

Despite the region's success in achieving a high level of care engagement and viral load suppression, significant disparities in HIV continuum outcomes continue to exist, particularly in regard to **ethnicity**. As noted in the comparison chart that follows the overall HIV continuum table, for example, while **81%** of white PLWH are retained in care (defined as at least 1 HIV-related lab test per year) only **76%** of Latino populations are retained in care. Additionally, while **75%** of white PLWH achieved viral suppression in 2017, only **67%** of African American and **68%** of Latino populations had achieved viral suppression. These and other disparities are aggressively addressed both in our proposed FY 2019 EIIHA Plan and in our proposed FY 2019 Part A care retention strategies, which include population-specific initiatives to better ensure long-term retention and medication



(a) Includes persons diagnosed before 2017 who were alive and residing in EMA at end of 2017.
(b) >= 1 CD4, VL or genotype tests during 2017.
(c) >= 2 CD4, VL and/or genotype tests at least 3 months apart during 2017.
(d) Last VL during 2017 <=200 copies/mL.



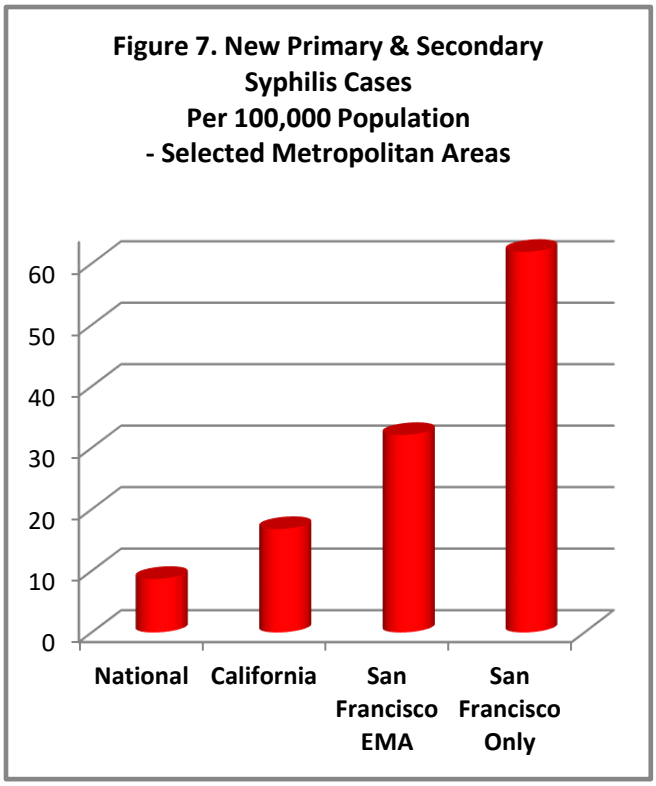
(a) Includes persons diagnosed before 2017 who were alive and residing in EMA at end of 2017.
(b) >= 1 CD4, VL or genotype tests during 2017.
(c) >= 2 CD4, VL and/or genotype tests at least 3 months apart during 2017.
(d) Last VL during 2017 <=200 copies/mL.

adherence, including the significant expansion of support for **medical case management** to provide focused retention support to populations facing complex life challenges.

3. Co-Occurring Conditions

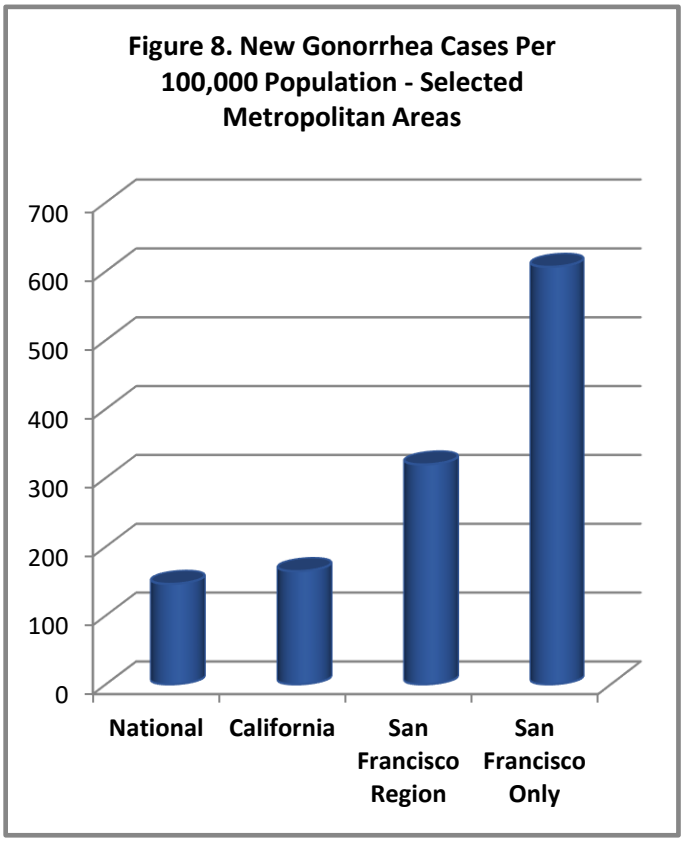
Please see **Co-Occurring Conditions Table** in **Attachment 4.**

Sexually Transmitted Infections (STIs): The San Francisco EMA as a whole - and the city of San Francisco in particular - are in the midst of a growing and unprecedented epidemic of sexually transmitted infections. While this epidemic reflects a larger, ongoing epidemic affecting the entire State of California, it is having particularly acute consequences for our region, and speaks to our need to redouble our efforts to continue to reach and test persons at high risk for HIV. In terms of **syphilis**, for example, the SF Jurisdiction continues to confront a major epidemic that has been escalating for the past two decades, rising more than **550%** since 2000. In calendar year 2017, a total of **628** new primary and secondary syphilis cases were diagnosed in the three-county San Francisco region, representing a **174%** increase over the **229** cases reported 10 years earlier in 2007.[17] The combined SF jurisdiction-wide syphilis rate of **32.1** per 100,000 in 2016 is nearly **twice** the California statewide rate of **16.8** per 100,000. Within the City of San Francisco alone, a total of **545** new syphilis cases were reported in 2017 for an extremely high citywide incidence rate of **61.9** cases per 100,000, a rate nearly **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 2016 (see **Figure 7**). **San Francisco County has by far the largest syphilis infection rate of any of California's 59 counties, 21.6% higher** than the rate of the second highest county, San Joaquin County (**50.9** per 100,000) and more than **three times** that of Los Angeles County (**19.5** per 100,000).



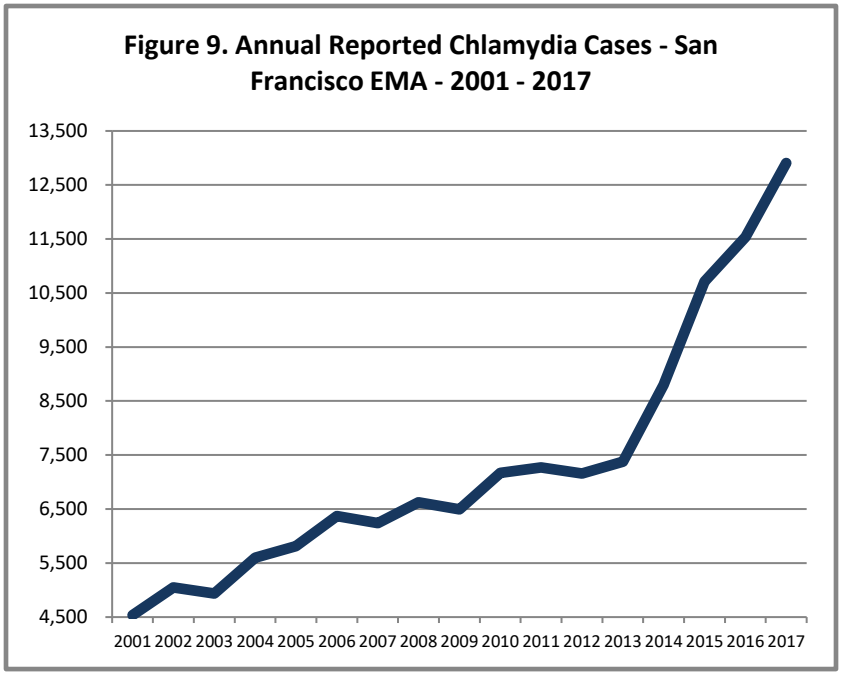
The region is also experiencing a significant **gonorrhea** epidemic. A total of **6,819** new gonorrhea cases were identified in the San Francisco EMA in 2017, for a Jurisdiction-wide incidence of **359.4** cases per 100,000 – a rate **nearly double** the 2017 California rate of **190.3** cases per 100,000 (see **Figure 8**).[18] The number of new gonorrhea cases in the city of San Francisco increased by **200%** between 2010 and 2017 alone, growing from **1,927** reported cases in 2010 to **5,779** cases in 2017. The City of San Francisco's 2017 gonorrhea incidence of **656.4** cases 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 (**190.3**). 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 **286.2** per 100,000, less than **half** the gonorrhea rate of San Francisco.



The region's **Chlamydia** epidemic also continues to increase, with rates rising precipitously. A total of **12,906** new cases of Chlamydia were diagnosed in the three-county region Jurisdiction in 2017, representing a **122%** increase over the **5,816** cases diagnosed in 2005 (see **Figure 9**).[19] The 2017 Jurisdiction-wide Chlamydia incidence stood at **680.5** per 100,000, while the rate for the City of San Francisco was a stunning **1,031.1** cases per 100,000 - again, by far the highest Chlamydia incidence rate of any county in California. By comparison, the 2016 incidence for California was **552.2** cases per 100,000, while the national rate was **497.3.**

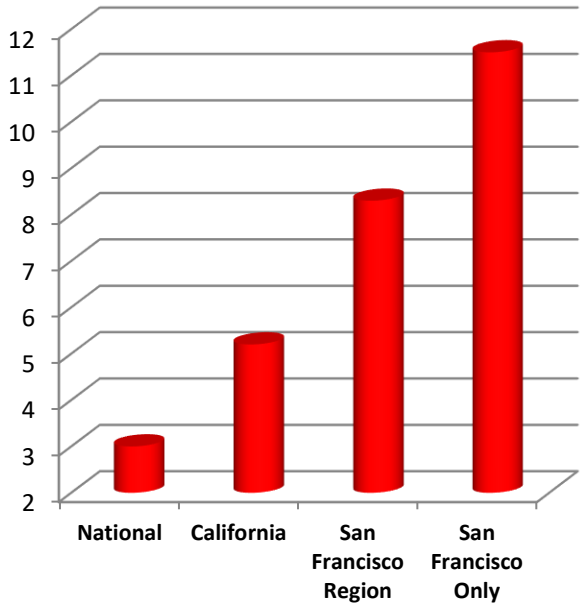
The cost of treating STIs adds significantly to the cost of HIV care in the San Francisco Jurisdiction. According to a study which estimated the direct medical cost of STIs among American youth, the total annual cost of the 9 million new STI cases occurring among 15-24-year-olds totaled $6.5 billion 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 **$13.9 million** per year, including an estimated **$1.95 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 **166** new cases of TB diagnosed in the three-county region in 2017, representing an area-wide incidence of **8.8** cases per 100,000. In San Francisco, the incidence is even higher, at **12.1** 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.

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



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.[20] 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.[21] 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.[22] 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%.**[23] 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.[24]

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 in 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.[25] 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.[26] 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**.[27] 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,[28] and recreational crystal use has been linked to **30%** of San Francisco's new HIV infections in recent years.[29]

4. Complexities of Providing Care

a. Reduction in Part A Formula Funding:

i. Impact: For the **4th consecutive year**, the San Francisco EMA experienced a slight reduction in Part A formula funding, with formula funds decreasing by **$159,631** from FY 2017 to FY 2018, a reduction of **1.7%** in the formula award. For the previous 3 years, these reductions had been offset by increases in the region's supplemental funding awards. However, between FY 2017 and FY 2018, the SF EMA also experienced a reduction of **$219,726** in our Part A supplemental award, resulting in a reduction of **2.5%** in our overall combined Part A formula and supplemental funding. The Planning Council utilized pre-established contingency plans which applied this reduction to proportional cuts in Part A support services.

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 3/1/17 - 2/28/18	
Federal Poverty Level (FPL)		
0 - 138% of FPL	5,420	73.8%
139% - 250% of FPL	1,109	15.1%
251 - 400% of FPL	290	3.6%
401% of FPL and Higher	60	1.0%
Current Living Situation		
Stable	4,847	67.1%
Temporary	1,611	22.3%
Unstable	383	5.3%
Insurance Status		
Private	629	8.7%
Medicare	2,167	30.0%
Medicaid	4,580	63.4%
No Insurance	2,052	28.4%
Other	3,453	47.8%

- Basic Threshold for Ryan White Eligibility in SF EMA: **400% or Less** of Current FPL
- Note: Chart excludes individuals for whom poverty or insurance status is unknown

c. Factors Limiting Access to Health Care / Service Gaps

Factors Limiting Health Care Access: 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 2017-2018 with the EMA's combined PLWH population as of 12/31/17 (see **Figure 12**). Because of the high cost of living in our region, the qualifying threshold for RWHAP eligibility in the SF EMA is **400%** of Federal Poverty Level (FPL).

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 - 3/1/17 - 2/28/18		Combined SF EMA PLWH Population as of 12/31/17		Population Variances - Ryan White vs. All PLWH
Race/Ethnicity					
African American	1,399	19.4%	1,933	12.4%	**+ 7.0%**
Latino / Hispanic	1,925	26,6%	3,495	22.4%	**+ 4.2%**
Asian / Pacific Islander	456	6.3%	1,100	7.1%	**- 0.8%**
White (not Hispanic)	2,954	40.9%	8,451	54.3%	**- 13.4%**
Other / Multiethnic / Unknown	490	6.8%	594	3.8%	**+ 3.0%**
	7,224	**100%**	**15,573**	**100%**	
Gender					
Female	844	11.7%	1,035	6.6%	**+ 5.1%**
Male	6,117	84.7%	14,139	90.8%	**- 6.1%**
Transgender	263	3.6%	399	2.6%	**+ 1.0%**
	7,224	**100%**	**15,573**	**100%**	

Demographic Group / Exposure Category	Total Unduplicated Clients Enrolled in Ryan White Services - 3/1/17 - 2/28/18		Combined SF EMA PLWH Population as of 12/31/17		Population Variances - Ryan White vs. All PLWH
Age					
0 - 24 Years	106	1.5%	156	1.0%	**+ 0.5%**
25 - 44 Years	2,005	27.8%	4,024	25.8%	**+ 2.0%**
45 - 64 Years	4,277	59.2%	9,376	60.2%	**- 1.0%**
65 Years and Above	836	11.6%	2,017	13.0%	**- 1.4%**
	7,224	**100%**	**15,573**	**100%**	
Transmission Categories					
MSM	4,055	56.1%	11,249	72.2%	**- 16.1%**
Injection Drug Users	785	10.9%	981	6.3%	**+ 4.6%**
MSM Who Inject Drugs	634	8.8%	2,064	13.3%	**- 4.5%**
Non-IDU Heterosexuals	820	11.3%	1,022	6.6%	**+ 4.7%**
Other	100	1.4%	55	0.3%	**+ 1.1%**
Unreported / Unknown	830	11.5%	202	1.3%	**+ 10.2%**
TOTAL	**7,224**	**100%**	**15,573**	**100%**	

Attesting to our region's success in bringing the most highly impoverished and challenged persons with HIV into Ryan White care, **persons of color, cis women, trans women, younger adults, injection drug users,** and **heterosexuals** are all **over-represented** in the local Ryan White system. Meanwhile **whites, men, MSM**, and **older adults** are **underrepresented** in the system due largely to higher average incomes and higher rates of private insurance, including Medicare in the case of older adults, which reduce their need to rely on Ryan White-funded care. For example, while women make up only **6.6%** of all PLWH in the EMA, they comprise **11.7%** of all Ryan White clients as of February 28, 2018. Meanwhile, while whites make up **54.3%** of all PLWH in the EMA, they comprise only **40.9%** of Ryan White Part A clients as of the same date. Ryan White clinics provide primary medical care to a population that is disproportionately comprised of persons of color, cis and trans women, persons with low incomes, the homeless, heterosexuals, current and former injection drug users, and formerly incarcerated individuals. 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 **19.4%** of Ryan White clients in the local Ryan White system are African American (n=**1,399**) despite the fact that they comprise **12.4%** of all persons with HIV in the EMA. The total population of African Americans in the Ryan White system increased by **36.9%** over the last year alone, from **1,022** African Americans in the system for FY 2016-2017 to **1,399** for FY 2017-2018. Similarly, Latino populations make up **22.4%** of PLWH in the EMA but comprise **26.6%** of Ryan White clients. Trans women make up **3.6%** of persons served through the Ryan White system while making up **2.6%** 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 2017 alone, the number of clients in the local Ryan White system increased by **11.1%**, from **6,503** total clients served in FY 2014 to **7,224** total clients served in FY 2017.

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 ▪ 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 Parts 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, the Long-Term Care Coordinating Council, and the HIV Housing Work Group 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[30]**

1. Planned FY 2019 EIIHA Activities

a. Primary Activities To Be Undertaken:

The FY 2019 EIIHA Plan will encompass **three** broad, high-impact prevention (HIP) activity areas which mirror those of preceding EIIHA plans, and which build on the significant progress the SF EMA has made through its **Getting to Zero (GTZ)** initiative. The **first** area involves identifying individuals who are unaware of their HIV status. The EMA will continue to maintain: a) high-volume, community-based **targeted HIV testing** for MSM, persons who inject drugs (PWID), and transgender women, incorporating the latest testing technologies as appropriate, including high-quality rapid testing and acute RNA pooled screening and rapid 4th generation combination antibody / antigen (Ab/Ag) tests at sites that do not have access to pooled RNA testing; b) integrated HIV/STI testing wherever feasible and appropriate, incorporating chlamydia, gonorrhea, syphilis, hepatitis B and C, and tuberculosis testing; c) routine testing of partners of HIV-positive individuals; d) routine opt-out screening in clinical settings; e) routine perinatal screening; and f) accessible, high quality laboratory-based HIV testing and case reporting. At the same time, over the next three years, the SF EMA will cast a wider net to: a) address disparities in new infections among African Americans and Latinos and b) find cases in low incidence populations such as women. These efforts will include: a) implementing culturally specific community engagement and mobilization with communities of color; b) further normalizing and de-stigmatizing HIV and STD testing to reach beyond those who traditionally test by continuing to expand medically based HIV opt-out testing with 3rd party reimbursement; and c) exploring opportunities to expand integrated approaches to sexual health services in novel settings such as HIV/STD screening and PrEP delivery at pharmacies.

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 continue to 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 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. 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. This 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.

The **third** key activity aims to promote and facilitate ever-widening utilization of **pre-exposure prophylaxis (PrEP)** throughout the EMA, and in particular, to address disparities in PrEP uptake. 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.[31] Key elements of San Francisco's PrEP strategy include the following:

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

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:

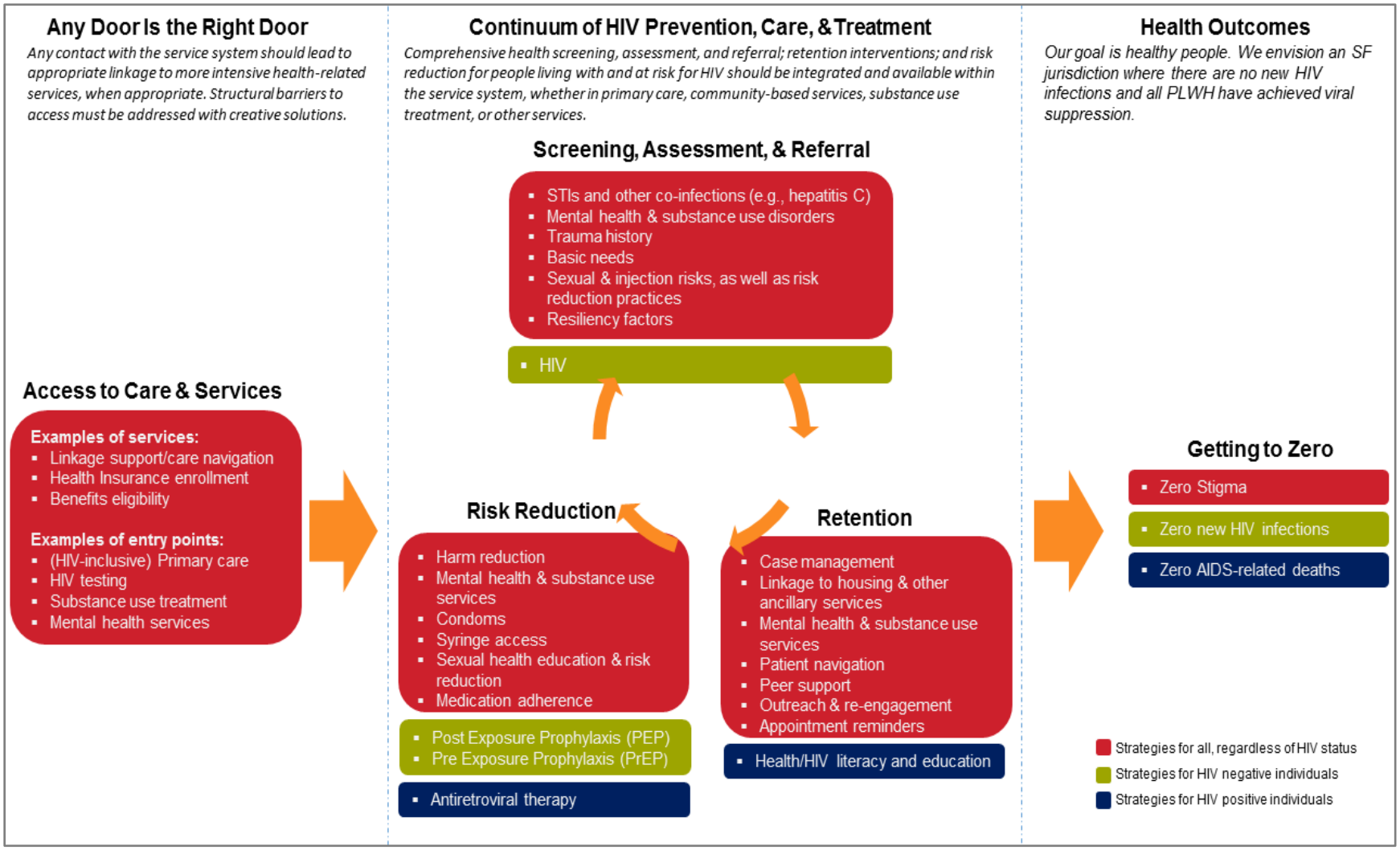
- Reducing **at risk** and **HIV-infected** populations by improving awareness and uptake of PrEP, with a particular focus on African American and Latino MSM, young MSM, and trans women;
- Increasing awareness of HIV status through increasing access to routine HIV testing and community-based rapid testing 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; and
- Continuing to conduct **Data to Care (DTC)** activities as a joint initiative between HIV surveillance and the LINCS program, with a special focus on African American and Latino MSM and trans women and expanding these efforts into a new **Data to PrEP** model.

Additionally, San Francisco conducts a **medical chart review** of **every** person living with HIV in San Francisco **every 12 months** to document and update variables not collected at time of initial diagnosis, including vital status, use of additional therapeutic and prophylactic treatments, subsequent opportunistic illnesses, most recent address, and additional CD4 and viral load results. This process also allows us to track and maintain a **current address for all PLWH**, which is a key component to the success of the DTC and LINCS programs. Address information is **geocoded to the census tract level,** enabling HIV surveillance to produce maps shared in our annual epidemiology report and to our prevention partners that show, for example, the geographic distribution of all PLWH, newly diagnosed cases and their viral suppression and linkage to care rates, as well as testing rates by age and zip code.

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

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



HIV testing, PrEP, and HIV early care); and ARCHES maintains the SF spectrum of engagement data as well as facilitating data to care and data to PrEP strategies. In addition, the DPH Primary Care Division is a close partner, providing routine HIV testing, care 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 merged HIV prevention and care community planning group, which includes HIV prevention and care service providers from all three counties as well as prevention and care consumers, and 2) the **Getting to Zero (GTZ) Consortium**, a multi-sector independent consortium of public and private sector agencies, service providers, consumers, and planners operating under the principles **of collective impact**. Modeled after the UNAIDS 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 2019 San Francisco EMA EIIHA Plan has **three** primary goals: **1)** to increase the percentage of individuals in Marin, San Francisco, and San Mateo counties who are aware of their HIV status; **2)** to increase the percent of HIV-positive individuals in our region who are effectively engaged in HIV care; and **3)** to reduce disparities in PrEP uptake, HIV infection, HIV testing, and successful and sustained linkage to care. SF EMA's EIIHA plan also includes approaches designed to reach the specific communities and individuals who are most vulnerable to HIV infection **before** they become infected. If GTZ is successful, the need for an early intervention plan should greatly diminish, because new infections will be virtually eliminated. These and other activities to be carried out by the San Francisco

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 represents an 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 2019 San Francisco EIIHA plan will reach many individuals who are disconnected from the system in order to bring them into HIV prevention, testing, linkage, and care services. Routine HIV testing, targeted community outreach, expanded case management services, and PrEP services specific to underserved communities will help to reduce disparities among groups such as MSM of color, substance users, African American women, uninsured and economically impoverished populations, homeless persons, and young MSM – all populations that have experienced historical HIV access and treatment disparities along with high rates of late HIV testing. The San Francisco EMA will utilize its EIIHA plan and matrix to focus on increasing awareness of HIV status and promoting treatment utilization among underserved populations as a way to continue to address HIV-related health disparities.

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, a shift that is made more likely with the advent of **PrEP Assistance Programs (PrEP-AP)** which help support the cost of PrEP medications for qualifying individuals.

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 2019 San Francisco EMA EIIHA Plan:

1. **Males Who Have Sex with Males (MSM)**
2. **People Who Inject Drugs (PWID)**
3. **Trans Females Who Have Sex with Males (TFSM)**

The San Francisco EMA's FY 2019 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 **85.5%** of all persons living with HIV cases in the region as of December 31, 2017, while non-MSM PWID make up another **6.3%** 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, a 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, 2017.

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:

- Implementing a pilot mentoring program for young gay men and trans females that supports the development and maintenance of personal strategies for supporting sexual health;

- Developing and implementing 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;
- Developing and disseminating PrEP Standards of Care through the San Francisco Department of Public Health, including standards on administering, tracking, and managing PrEP;
- Implementing 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;
- Exploring 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;
- Developing and implementing new models for integrating geriatric specialists into the HIV clinic setting;
- Recognizing 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 aging among HIV populations; and
- Creating 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.

San Francisco is also in the process of developing a new initiative called **Project OPT-IN** (Opt-In to Outreach, Prevention & Treatment), specifically designed to reduce HIV-related disparities and health inequities across the spectrum of prevention, care, and treatment for **homeless populations living with and at risk for HIV.** The vision of Project OPT-IN is to create a network of homeless services that meets the needs of people living with or at risk for HIV, providing them with all the resources and support needed to stay HIV-negative or virally suppressed. Among other innovations, Project OPT-IN will create a new **HIV Prevention Services Outreach Team (PSOT)** that will conduct homeless health outreach both at the individual level and through inter-agency partnerships, identify new or out of care homeless persons living with or at risk for HIV, and collaborate with medical and social service providers to link and anchor these individuals in care. Project OPT-IN will improve HIV-related outcomes across the care continuum by providing services to address critical gaps in HIV prevention and care services for the target populations, while simultaneously working to transform systems and practices, thus reducing the long-term need for such services. San Francisco is also working toward becoming the first city in the US to implement a **safe heroin injection site** under the leadership of the city's new mayor, London Breed. The site will provide a space for persons to inject drugs safely without fear of arrest, while accessing HIV testing and other supportive and treatment services.

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 2019 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.[32] 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, while 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.

C. AIDS Pharmaceutical Assistance

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

- **METHODOLOGY**

A. Impact of the Changing Health Care Landscape

1. <u>Overview of Regional Health Care Options:</u>

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.[33] 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.[34] The vast majority of these individual are eligible for premium tax credits expected to range from 36% to 54% of enrollees in 2014.[35] 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.[36] 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.

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 relied 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 service funding request for the 2014 Ryan White fiscal year, that percentage has dropped to **7.8%** for the current FY 2019 funding request, including MAI funding. 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 **26.2%** 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. **13.7%** in FY 2017) and non-medical case management (**3.3%** in FY 2014 vs. **14.1%** in FY 2017). Expanded ACA-related reimbursements directly led to the EMA's decision to successfully apply for an annual 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 2019 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 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 2018 and then voted on resource allocation funding scenarios at its annual **Prioritization and Allocation Summit**. 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 2019 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. <u>How PLWH are Involved in the Planning and Allocation Process:</u> As in previous years, persons living with HIV (PLWHs) were integrally involved in all phases of the FY 2019 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** new 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 Housed 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 last 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 2019 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 2019 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 2018 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 2017 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, 2017 through February 28, 2018, 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 the 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 2018 to FY 2019:

Apart from the continuing, multi-year trend of shifting Part A dollars from direct medical care services to services that support patient retention in care, no significant prioritization and allocation changes took place between the current Part A fiscal year and the upcoming 2019 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 2019 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 2019 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 a 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 of the 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**
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 Parts 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. HIV Care Continuum Table: Please see table in **Attachment 7.**

2. HIV Care Continuum Narrative:

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

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) MAI and Overall Service Category Plan Narrative:

The FY 2019 Part A Plan requests a total of **$16,202,233** 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 **89.8%** of this total request, for a total of **$14,522,576**. Another **$367,500** supports EMA-wide quality management activities, while **$1,290,148** 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 **7.4%** of the FY 2019 direct service request supports HIV client services in **San Mateo County**, while another **3.0%** 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 2019 service expenditures – **62.9%** of total requested service dollars (**$9,151,733**) - support the provision of direct care services in HRSA-identified **core service categories**. Of this year's total direct service request, a total

of **$1,136,298** is requested for **outpatient / ambulatory health services** (including **$15,364** in Part A MAI funds), an amount representing **8.8%** of the total core services request and **7.8%** of the total FY 2019 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. This represents the lowest percentages of Part A funding for direct medical services ever requested by the San Francisco EMA, and reflects both the dramatic impact of the Affordable Care Act on the financing of low-income health care in California and the innovative work of SF providers in utilizing multiple funding streams and developing collaborative approaches to support and streamline patient care. Additional HRSA core categories for which significant funding is requested in the FY 2019 Plan include: a) **Medical Case Management** that links and coordinates assistance from multiple agencies and caregivers in order to ensure access **and** promote retention in care and adherence to medical treatment (**$3,808,953 ,** including **$476,681** in requested MAI funds); b) **Mental Health Services,** including Crisis and Outpatient Mental Health Services (**$1,991.511**, including **$140,492** in MAI funding); c) **Oral Health Care** to address critical dental manifestations of HIV and preserve overall client health (**$846,582**); **d**) **Hospice Services** supporting room, board, nursing care, counseling, physician services, and palliative care for clients in terminal stages of illness (**$823,921**); and e) **Home Health Care** to meet direct medical treatment needs outside of inpatient and clinical settings (**$284,553**).

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 **30.5%** of all new HIV diagnoses in CY 2017 alone. Between 2011 and 2017, Latino PLWH in the EMA grew by **44.5%**, from **15.5%** to **22.4%** 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.[37]

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 helps support the cost of medical case management, mental health counseling, and substance abuse services. MAI-funded peer and treatment advocates also help clients make informed decisions about medications, and work with them to identify and remove barriers to adherence.

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 2017-2018 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 psychosocial 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 a 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 2019 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 a 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

- **EVALUATION AND TECHNICAL SUPPORT CAPACITY**

A. Clinical Quality Management (CQM)

1. <u>Using Performance Measures to Analyze and Address Disparities:</u>

The San Francisco EMA maintains a well-established quality management infrastructure that enables consistent analysis and problem solving of issues related to client care and to lack of equity in regard to HIV care outcomes. The **Director of HIV Health Services,** Bill Blum, oversees the creation, implementation, and evaluation of continuous quality improvement (CQI) activities that are in turn supervised and managed by the **Quality Improvement Coordinator.** The SF EMA **Quality Improvement Committee**, comprised of members with diverse perspectives on quality of care, is responsible for selecting and implementing a targeted and specific CQI effort for Ryan White Part A funded providers annually and updating the local Quality Management Plan. The Committee also prioritizes and implements new QI projects; provides continuous QI and topical training; responds to providers' needs by utilizing the National Quality Center's (NQC) Quality Indicator measures and tools; and updates performance indicators to satisfy quality measures. The chart below briefly outlines responsibilities of staff and committees involved in the EMA's quality improvement effort (see **Figure 15**):

Figure 15.
Chart of Responsibilities for SF EMA Clinical Quality Management Program

Individual / Entity	Role / Responsibilities
▪ **HHS Director**	▪ Provides fiscal oversight; approves overall plan; reviews and tracks implementation of work plan.
▪ **HHS Assistant Director**	▪ Tracks implementation of work plan; directly supervises CQI staff.
▪ **Quality Improvement Coordinator**	▪ Coordinates operations of CQI; assists in overall QI development; generates analyses and reports; oversees day-to-day development of program; **shares QI performance reports with providers;** attends planning meetings; reviews existing literature related to quality development and improvement; coordinates capacity building activities.
▪ **HHS ARIES Team**	▪ Monitors HHS ARIES Database; monitors client and service level data compliance standards; assists in designing CQI plan; advises on performance indicators; creates reports from raw data; analyzes and reports on CQI results; trains and updates provider users as needed.
▪ **San Mateo and Marin Co. QI Representatives**	▪ Oversees all Quality Management activities in their counties and respective providers.

To effectively track and address local HIV-related care and outcomes disparities, several critical aspects of care are monitored throughout each contract year, including primary care health QI outcomes, provider education, client satisfaction, continuity of care, case management services, and client medical records. The San Francisco EMA utilizes the HRSA HAB performance measures tracked through ARIES. Reports on the various performance measures are generated on a routine basis and delineate both the aggregate data for the EMA and agency-specific data for the Centers of Excellence. This data allows the EMA to assess tracking of health outcomes and evaluate system-wide or agency-specific issues in both client care and data collection. System-wide issues are discussed with the Director of HIV Health Services, the Quality Improvement Coordinator, data collection specialists at HIV Health Services, and providers at the monthly Centers of Excellence meetings. These meetings serve as a forum for discussing care-related issues and performance measures and are attended by the QM consulting staff. Additionally, ARIES-generated QI data are utilized to measure program performance objectives standardized across several service categories such as Ambulatory/Outpatient Health Services, Medical Case Management, Mental Health Services, Hospice, and others.

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

The well-established Quality Management infrastructure enables consistent analysis and problem solving of issues related to client care. The Director of HIV Health Services oversees the creation, implementation, and evaluation of QI activities that are in turn supervised and managed on a day-to-day basis by the HIV Health Services Assistant Director, with support from the Administrative Analyst, the HHS Quality Improvement Coordinator, and the ARIES Site Manager. Under these individuals' supervision, and in collaboration with providers, quality components are developed and implemented in collaboration with other services and administrative staff from the selected programs. Additionally, consultants with a wide range of diverse skills and expertise may support the QM program through the provision of services such as training, technical assistance, program evaluation, and administrative support. During Ryan White 2018 Fiscal Year, HHS is implementing a CQI initiative specifically focused on improving viral load suppression among **African American** clients.

HIV Health Services distributes an **annual training needs assessment survey** to Part A-funded agencies to prioritize quality management projects and improvement areas

within the regional Ryan White system in relation to HIV disparities. Continual agency monitoring also provides an opportunity for HHS to identify areas for quality management improvement among providers. Through established processes, HHS staff alert the Quality Improvement Coordinator whenever a problem or issue is identified, and an agency assessment is quickly initiated. Based on this assessment, a **technical assistance plan** is developed and implemented in collaboration with the agency to provide skills-building and support for improving client care. Regular assessments of subcontractor agencies include a review of the previous year's RSR data completeness report; a review of the agency's data flow processes; identification of key staff who collect data; where collected data are stored; how **programming is created so that** data **can be mapped and imported into** ARIES; and who reviews ARIES data quality. Data elements and/or indicators that fall short of compliance standards are specifically examined for all QI projects. HHS encourages the utilization of Plan-Do-Study-Act (PDSA) cycle models for quality improvement projects at individual agencies. In June of 2017 HHS utilized a trainer from the National Quality Center to conduct a training for Ryan White Part A funders on strategies for improving their CQI activities at their individual programs.

For agency-specific issues, the EMA has established a **written protocol** for accessing Technical Assistance through the Quality Management Program. Agency-specific issues are discussed with the Director and Administrator of HIV Health Services, the DPH Business Office of the Contract Compliance Manager, and the Quality Management Consultant. Typically, a **written technical assistance plan** is developed - such as a chart review or staff training - and implemented with one of the Quality Management TA consultants and the agency. Progress is updated with the Business Office of the Contract Compliance Manager, Contract Development, and Technical Assistance Manager; **if required** a report, including any further recommendations, is submitted to the HIV Health Services Administrator and Director and the agency at the completion of the technical assistance period.

Annual agency site visit monitoring provides another opportunity for monitoring and evaluating the Quality Management Plan. Client satisfaction and staff training for Standards of Care and Best Practices are monitored by HIV Health Services and any issues are identified for technical assistance. Provider meetings and training evaluations from provider trainings and workshops can also serve as useful mechanisms for evaluating **and updating** the Quality Management Plan.

2. <u>How CQM Data Is Used to Improve or Change Service Delivery:</u>

Current indicators are reviewed by the CQI Committee to ensure specificity, relativity, accuracy, and traceability to the needs of clients and to identify and help develop strategies to address HIV-related health disparities, especially in regard to Viral Load Suppression and percent of clients prescribed ART. Data analysis is initially prepared by HHS staff with input from the other EMA county staff for verification of findings. Data reviews also take place during HHS provider meetings. Data analysis continually incorporates comparison with epidemiologic and care continuum data to identify progress toward reducing disparities, and to plan responses to disparity issues. Meanwhile, HHS staff provide ongoing updates and information on quality management activities to the San Francisco HIV Community Planning Council. The HIV Health Services QI Coordinator provides regular

formal progress reports to the Council on the status of the quality management program and the client-level data system. HHS prepares an annual EMA CQI presentation which consists of a description of all indicators including national and local threshold performance goals; a graphic depiction for each which illustrates aggregate results by county; an analysis of data findings; a statement of whether or not performance goals were met; and reasons if not met and next steps for quality improvement. In addition, a five-year trend chart of the QM indicators is shared on at least an annual basis with the Council.

Based in part on quality management data received, the San Francisco Planning Council has reaffirmed the continuing focus of the EMA's Centers of Excellence on **persons with severe need** and **special populations**. Recent refinements made by the Planning Council based on the use of data include: a) expanding the EMA's definition of special populations to include PLWHA age 60 and older; b) integrating existing Early Intervention Programs into the CoE model; and c) for the purposes of the CoE, specifying the inclusion of individuals living in neighborhoods in which health disparities and HIV are co-prevalent including the Tenderloin, the Mission, South of Market, and the Southeast Corridor of San Francisco.

HIV-infected consumers play a critical role at all levels of the SF EMA CQM planning and implementation process in relation to addressing HIV disparities. The San Francisco HIV Health Services Planning Council and its quality committee – a majority of whom are persons living with HIV – review, revise, and participate in producing CQM standards, systems, and support. At the agency level, subcontractors rely on ongoing client satisfaction surveys to assess the qualitative impact and effectiveness of agency services, while working directly with consumers to collect required data and ease the burden of data collection and reporting on clients. The results of consumer needs assessment processes also directly influence the design and implementation of CQM projects, as do findings related to changing client utilization of Ryan White Part A services. Also, as previously mentioned, HHS meets quarterly with other Part C grantees from greater Northern California under the guidance of the National Quality Center. HHS also meets with Alameda TGA staff to discuss continued quality improvement activities which focus on data collection, input and analysis.

Recent trainings have been conducted on the following topics: **a) Motivational Interviewing:** This training offered providers a practical, common sense approach for supporting clients in making and sustaining healthy behavior changes. **b) Immigration Workshop for HIV Providers:** This training provided skills, tools, and resources for providers to better support people who are undocumented immigrants and refugees within the HIV + community. **c) Crisis Communication and De-escalation:** This training providers with the basics in identifying, preventing and effectively navigating crisis through communication and de-escalation. **d) Group Leadership in Community Work:** This workshop focused on common issues and topics for group leaders, including group guidelines, dealing with challenging participants, common group leader struggles, dealing with conflict and being devalued as a group leader. **e) Group Work Consultation, Leadership via Case Studies:** This training followed and built upon the Group Leadership in Community Work training and emphasized specific case studies brought by participants in their roles as group leaders. **f) Expansion of San Francisco's Quality Management/Quality Improvement Program:** This training offered technical assistance to align with national priorities, assisted providers to reach the next performance level and

sustain a mature management program, and taught Best Practices to assess and update providers' quality management program. **g) Burnout Prevention:** This training explored with participants the causes, consequences and symptoms of stress and burnout among health and social service staff working with PLWH. **h) Unearthing Implicit Bias, Working Effectively with Diverse Populations:** This training offered practical skills to identify implicit bias in providers' interactions with clients and colleagues, and offered steps to support and repair relationships. **i) Effectively Supporting Safe Inclusive Spaces for LGBTQ Clients and Colleagues:** This workshop presented participants with basic concepts, vocabulary, and skills necessary to provide the best support for intersex, transgender, and other sex/gender non-conforming clients and colleagues. **j) Racism and White Privilege: Navigating difficult personal conversations on racial inequity:** This workshop deepened providers' understanding of the impacts of racism and reviewed how cultural competency and racial identity education can support positive change. **k) Understanding and Interrupting the Cycle of Oppression:** This training introduced to the cycle of oppression and ways to dismantle the cycle through examining and understanding stereotypes, prejudice, discrimination, and social power. **l) HIV Nursing Network Conference:** HIV Health Services and the AIDS Education and Training Center provide this training annually for nursing staff in the EMA. Topics covered include HIV 101; Updates on HIV Prevention; Mental Health, Homeless &HIV; Pharmacology Update; Intersection of STDs and PrEP; Managing Chronic Pain; Best Practices in Linkage and Retention; and a panel discussion with consumers across the continuum of care.

- **ORGANIZATIONAL INFORMATION**

A. Grant Administration

1. <u>Program Organization:</u>

a) <u>Administration of Part A Funds:</u>

The grantee agency for Ryan White Part A funds in the San Francisco EMA is the **City and County of San Francisco Department of Public Health (DPH).** Ultimate authority for the administration and expenditure of Part A funds lies with the city's newly elected **Mayor, London Breed**, and with the city's 11-member **Board of Supervisors**, which acts as both county governing board and city council for San Francisco. This authority is shared with **Greg Wagner, CFO for DPH** who also now serves as **Acting Director of Public Health** for the City and County of San Francisco (see Organizational Chart in **Attachment 10**). The administrative unit overseeing the Part A grant is **HIV Health Services (HHS)**, an organizational unit of the San Francisco Department of Public Health, Primary Care division, overseen by **Roland Pickens,** who serves as **Director for the San Francisco Health Network** for the City and County of San Francisco**.** The **Director of HIV Health Services** is **Bill Blum, LCSW,** who has served in this capacity for **9½ years and serves as Director of Programs for Primary Care in DPH**. A staff of **9 SFDPH** employees **(8.8 FTE)** - each funded with different levels of Part A support - is responsible for directing, coordinating, and monitoring the distribution and expenditure of Part A funds throughout the EMA, working a combined total of **2.40 FTE with Part A funding**. Additionally, a

combined total of **2.05 FTE** of staff time is dedicated to Business and Finance Services; **0.33 FTE** to Surveillance/Epidemiology; **1.26 FTE** to Accounting Services; and **0.65 FTE** to the Contracts Administration section (see attached Budget Justification for description of individual staff roles and percentages).

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

The two additional counties that make up the San Francisco EMA have responsibility for administering and distributing Part A funds through their counties' respective health departments. In San Mateo County, Part A and Part B funds are coordinated through the **San Mateo County Health System's Director, Charlene Silva**. Responsibility for Part A fund administration lies with **Matt Geltmaker,** who serves as **Director of the San Mateo County STD/HIV Program** and is responsible for oversight of all Ryan White Part A, Part B, MAI, CDC, HIV prevention, and HOPWA funds as well as subcontractor oversight. In Marin County, Parts A and B funds are administered through **County of Marin Health and Human Services**, whose Director is **Dr. Grant Colfax, M.D.** He shares responsibility for Part A funds with **Maureen Lewis, Chief Assistant Director of Public Health Services.** The **Marin County HIV/AIDS Program** has direct responsibility for Part A fund management and coordination. Direct oversight of Marin Part A funds is provided by **Cicily Emerson, Community Health and Prevention Services Manager** for the County. An EMA-wide Organizational Chart outlining the above relationships is included in **Attachment 1** of this application.

b) <u>Administration by a Contractor or Fiscal Agent:</u>

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

2. Grant Recipient Accountability:

a) Monitoring:

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

For the 2018-2019 Fiscal Year (3/1/18 - 2/28/19), the San Francisco Department of Public Health is utilizing Ryan White Part A funding to support a total of **42** separate programs. These 42 programs are being operated by **23** different community-based organizations, including local non-profits, the University of California San Francisco, and programs administered by the local county health department. SFDPH Business Office Contract Compliance staff conducted on-site monitoring visits to **all** of these programs in FY 2018 and will conduct programmatic and fiscal monitoring visits to **all** programs in FY 2018 as well. In addition, SFDPH participates in San Francisco's Citywide Nonprofit Monitoring and Capacity-Building Program, which conducts in-depth fiscal and compliance monitoring of all nonprofit contractors funded by two or more City departments. Additionally, in FY 2018-2019, SFDPH will participate in a fiscal review of all Ryan White Part A programs and in-depth monitoring site visits at **12** of the 22 organizations that receive Ryan White Part A funding.

For both the past and current Ryan White Part A fiscal year, there were no major monitoring findings that required corrective actions. If a specific programmatic concern is identified at a Part A-funded agency, information is **immediately** sought from staff of the contracted agency. Contractors may be asked to explain why deliverables are low, why a high staff turnover rate exists, or what actions have been taken to resolve a specific consumer grievance. A recommendation to address the issue is then collaboratively developed, usually accompanied by specific deliverables and target dates for redressing the issue, such as developing a modified work plan within 30 days or completing a process of staff training within 60 days. Providers are required to formally report on their progress in addressing such recommendations in a written action plan to be submitted within an established deadline, as well as during the following year's monitoring process. Grantee staff follows up on areas of concern after reports have been received. TA is provided for contracting agencies in areas such as staff training and orientation, adoption and replication of best practices, and/or collaboration. Agencies with ongoing problems are referred to the Fiscal Compliance Unit's Contract Oversight Committee which works to

develop a corrective action plan for the agency to maintain ongoing funding and good standing. As noted above, there are currently no RWPA funded programs involved in a Departmental Corrective Action Plan.

ii. Compliance with Single Audit Requirement: All HHS Part A-funded Contractors (100%) are required to provide an Audit report for the last fiscal year in compliance with Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR part 75). All 23 contractors have complied with this requirement.

iii. Improper Findings and Actions: There were no problems reported from subrecipient single audit or program-specific audit reports.

b) Third Party Reimbursement:

i. Ensuring Monitoring of Third Party Reimbursement: The San Francisco Department of Health is committed to maximizing third party reimbursement across the EMA to ensure that Part A funds are always used as the funding source of last resort. This is not only to comply with Ryan White Act requirements, but because the fiscal crises local and state systems are facing compels the region to maximize its reimbursement streams. To this end, all three SF EMA counties have taken steps to ensure that all available reimbursement sources in the region are fully utilized, including: a) continually educating providers on the availability of third-party reimbursement streams; b) expanding the capacity of local organizations to bill for services, including assistance in obtaining licensure and certification and developing electronic billing systems; c) training agencies to conduct eligibility screening and enrollment for clients, including training to help clients manage their own benefits and eligibility; and d) providing regularly updated information on emerging developments in reimbursements, rates, and requirements. The EMA has also taken steps to verify during the site visits and monitoring process that Part A contractors are fully maximizing reimbursement streams, and that rigorous protocols are followed to ensure that Part A funds are only used **after** all other funding sources have been exhausted. The generalized formula used by HIV service providers to determine client benefits eligibility is to lead each client through an **intake/registration procedure** in which standardized questions are asked pertaining to factors such as HIV status; residence; age; employment status; income; insurance; health status, and other factors to determine if third party insurance and Medicaid coverage are an option. Providers are then required to assist clients in obtaining all benefits for which they may be eligible, including referring them to agencies that provide benefits assistance. All HIV RFPs (Requests for Proposals) and contracts contain highlighted language stressing that Ryan White funds will be used **only** for services that are not reimbursed through any other source of revenue and new contracting agencies receive training to familiarize them with other appropriate payment sources for specific services and programs.

ii. Documenting Client Screening for Eligibility and to Ensure that Ryan White is the Payer of Last Resort: Service providers are monitored to ensure compliance with Ryan White Program policy and guidelines pertinent to third-party reimbursement.

Contracted service providers must provide a description of their screening practices for determining client eligibility for receipt of services, as well as a roster of all third-party payer sources they utilize. Local health department policies in all three EMA counties mandate that if a client is found eligible for coverage from a payer source other than Ryan White - such as Medicaid, Medicare, or private insurance – then that source **must** be billed before seeking reimbursement from Ryan White. **In these cases, payment received is considered as payment in full, and balance-billing to Ryan White is not permitted.** Technical assistance is provided where needed to ensure that agencies modify and improve their eligibility standards or attain greater competency in maximizing third-party billing procedures.

iii. Tracking Program Income and Rebates: HIV Health Services and the SFDPH Office of Contract Development and Technical Assistance require all agencies funded through Ryan White Programs to provide a complete budget summary of all program funding sources and incomes as well as program expenditures. All programs must demonstrate that their total program funding equals total program expenditures for each fiscal year in the budget.

c) Fiscal Oversight:

i. Process Used by Program and Fiscal Staff to Coordinate Activities and Ensure Adequate Reporting, Tracking, and Reconciliation of Program Expenditures: The staff of the City and County of San Francisco Controller's Office monitors federal funds awarded to nonprofit organizations. For nonprofit organizations receiving $750,000 or more in federal funds, the Controller's Office reviews audited financial statements and single audit reports for compliance with the Single Audit Act and OMB Circular A-133. In Fiscal Year (FY) 2016, the Controller reviewed single audit reports for a total of **23** SFDPH HIV Health Services funded organizations including **all** Part A-funded community based organizations. The Controller found that all of these organizations had appropriate and timely processes and practices in place.

San Francisco EMA programmatic monitoring, contract development, oversight, compliance and monitoring functions are overseen by the Department of Public Health's new Community Programs Business Office, created in an effort to consolidate services and maximize efficiencies. The centralized Business Office is staffed by **24** program managers from all SFDPH systems of care and consists of two sections: **1)** the Business Office of Contracts Compliance Unit (BOCC) and **2)** the Contract Development and Technical Assistance Unit (CDTA). The Contract Compliance Unit provides annual program review; conducts controller's fiscal and compliance review for SFDPH contracts; performs fiscal audits; oversees provider certification and licensing (PPN and Civil Service); performs site certification reviews; and, if indicated, oversees corrective action plan development and oversight. The Unit also ensures that contracted Part A programs: a) are effectively managed; b) meet their contract deliverables; c) serve their target populations in professional and culturally competent ways, including adhering to published standards of care; and d) maximize external resources to ensure that Ryan White dollars are always used as the funding source of last resort. Additionally, all EMA member counties employ strategies to clarify provider responsibilities, track contractor performance, monitor

service quality, and ensure maximum reimbursements. All BOCC and CDTA staff have been trained by HHS, which maintains regular and ongoing communication to inform them of all HRSA/HAB requirements and updates. HHS staff participate in all site visits with BOCC and review monitoring reports before they are finalized.

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

ii. Process to Separately Track Formula, Supplemental, MAI, and Carry Over Funds, Including Data Systems Utilized: HIV Health Services maintains a system for tracking all funding **by funding source** including formula and supplemental funds. Additional tracking systems that are used by SFDPH Contracts Unit and Fiscal Unit staff assigned to work with HHS. A **bi-weekly budget meeting** attended by staff from all four units ensures accurate tracking across programs. **For FY 2017, all Part A funds were put into contracts and there were therefore no unobligated dollars.** In FY 2017, HIV Health Services also conducted both a **service category** and a **program level analysis** based on past and current fiscal performance to assign and track formula and supplemental funds. Formula dollars were prioritized to fund core services and supplemental dollars were targeted to fund support services.

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

Accounts Payable – Contracts and Reconciliation section performs their final review and forwards to the Controller's Office for payment. Payments are either sent by check via U.S. Mail or deposited electronically into the contractors' bank account by SF's Auto Clearinghouse Payment Processing for those contractors who establish this mechanism with the City. Payments are processed once weekly.

B. Maintenance of Effort

Please see Maintenance of Effort report in **Attachment 11.**

ENDNOTES

[1] US Census Bureau, *California QuickFacts*, Marin, San Francisco, & San Mateo Counties, Accessed October 1, 2017.
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[6] Calculation based on annual projected average cost of $25,000 per person for HIV treatment x 15,573 total PLWH in EMA x .606, representing estimated percentage of all persons with HIV living in poverty.
[7] St. Lawrence, J. & Brasfield, T., "HIV high risk behavior among homeless adults," *AIDS Education Prevention*, 7(1):22-31, 1995.
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[9] US Department of Housing and Urban Development, FY 2018 Fair Market Rent Documentation System, Accessed October 2017.
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[15] Based on 48,908 persons living with HIV in Los Angeles County as of 12/31/14 with a 2010 Census population of 9,818,605 and 105,090 persons living with HIV in New York City as of 12/31/13 with a 2010 Census population of 8.175,133. Sources of AIDS data: Los Angeles County Department of Public Health, *2014 Annual HIV/AIDS Surveillance Report* and New York State Department of Health, Bureau of HIV/AIDS Epidemiology, *New York State HIV/AIDS Surveillance Annual Report for Cases Diagnosed Through December 2013.*
[16] Data Source: San Francisco Department of Public Health, HIV Epidemiology Section, Op. Cit.
[17] State of California Department of Health Services, STD Control Branch, "Primary and Secondary Syphilis, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2013-2017 Provisional Data," Sacramento, CA, August 2018.
[18] State of California Department of Health Services, STD Control Branch, "Gonorrhea, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2013-2017 Provisional Data," Sacramento, CA, August 2018.

[19] State of California Department of Health Services, STD Control Branch, "Chlamydia, Cases and Rates, California Counties & Selected City Health Jurisdictions, 2013-2017 Provisional Data," Sacramento, CA, August 2018.
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[21] Source: San Francisco Department of Public Health, Behavioral Health, estimates prepared for FY 2008 San Francisco EMA Ryan White Part A application.
[22] The San Francisco Injury Center, Op. Cit.
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[24] Mayne, T., et al., "Depressive affect and survival among gay and bisexual men infected with HIV," *Archives of Internal Medicine*, 156(19), October 1996.
[25] The Healthy Communities Institute and the Hospital Council of Northern & Central California, *Health Matters in San Francisco: Hospitalization Rates due to Alcohol Abuse*, San Francisco, CA, 2010.
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CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure of Lobbying Activities,'' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure of Lobbying Activities,'' in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION	San Francisco Dept of Public Health
* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
Prefix:	
* First Name:	Roxana
Middle Name:	
* Last Name:	Castellon
Suffix:	
* Title:	Director of Operations
* SIGNATURE:	Completed on submission to Grants.gov
* DATE:	Completed on submission to Grants.gov

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** 2019 Budget Narrative.pdf

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BUDGET SUMMARY - PART A
RECIPIENT: San Francisco Dept of Public Health
GRANT NUMBER: H89HA00006
FISCAL YEAR: 2019-20

☑ **Funding Opportunity Announcement (FOA)** ☐ **Program Terms Report**

	Part A Formula and Supplemental			Minority AIDS Initiative (MAI)			Total
Object Class Categories	**Administration**	**Quality Management**	**HIV Services**	**Administration**	**Quality Management**	**HIV Services**	
a. Personnel	$483,243			$57,544			**$540,787**
b. Fringe Benefits	$193,299			$23,017			**$216,316**
c. Travel	$4,600						**$4,600**
d. Equipment	$0						**$0**
e. Supplies	$6,471						**$6,471**
f. Contractual	$496,974	$367,500	$13,819,527	$0	$0	$725,048	**$15,409,049**
g. Construction							
h. Other	$25,000						**$25,000**

Direct Charges	**$1,209,587**	**$367,500**	**$13,819,527**	**$80,561**	**$0**	**$725,048**	**$16,202,223**
Indirect Charges							**$0**
TOTALS	**$1,209,587**	**$367,500**	**$13,819,527**	**$80,561**	**$0**	**$725,048**	**$16,202,223**
Program Income							**$0**

PART A ADMINISTRATIVE BUDGET NARRATIVE

RECIPIENT: San Francisco Dept of Public Health

GRANT NUMBER: H89HA00006

FISCAL YEAR: 2019-20

Personnel

FTE	Name, Position, Duties	Amount
0.20	Michelle Long, Director of CDTA, Charged with primary oversight of contract development, modifications, and renewals of all Ryan White Part A grants	$33,051
0.50	Debra Soloman, Director of Contract Compliance, Charged with oversight of contractor performance and compliance for Ryan White Part A grants	$71,383
0.40	Bill Blum, Director of HIV Health Services, Charged with primary oversight for the administration of services and day to day operations of HIV Health Services and the Ryan White Part A grant	$57,106
0.75	Francine Austin, CDTA Program Manager, Provides programmatic oversight and monitoring of case management and integrated services program	$85,586
0.60	Marsha Herring, Compliance Program Manager, Provides oversight of contractor performance and compliance for Ryan White Part A grants	$68,468
0.15	Joseph Cecere is the administrator of the HIV Health Services client services database (ARIES) is responsible for the staffing of the ARIES users trainings, managing the coverage for the ARIES helpdesk line and overall implementation and planning for communications, updates, and oversight of this system.	$17,117
0.05	Dean Goodwin is responsible for the overall planning, evaluation and quality management for HHS as the grantee for the San Francisco HIV System of Care in coordination with our Ryan White mandated HIV Health Services Planning Council.	$6,634
0.10	Kevin Hutchcroft, HIV Health Services & ADAP Coordinator,Conducts QM training program providing and many trainings annually for all our funded providers	$10,195
0.33	Anne Hirowaza, Epidemologist, Principal duties include data quality, satistical analysis and interpretation of findings, manuscript preparation and dissemination of findings.	$29,371
0.30	Irene Carmona, Contracts Manger, Supervises contract management staff and ensures contract development compliance.	$39,803
0.15	Nora Macias, Contract Analyst, Processes contracts and assures compliance with local, state and federal regulations.	$17,191
0.26	Vacant, Senior Accountant, Responsible for supervision and management of grant accountant activities. Certified grant revenues and expenditures for annual appropriation.	$23,694
0.25	Intern Accountant, This position is responsible for establishing appropriate classification structure within the general ledger account for grants and ensures claims/costs are in compliance with the appropriate regulations. This position is responsible for grant accounts payable activities and reconciles with expenditure reports and claims.	$15,951
0.50	Intern Accountant, This position is responsible for establishing appropriate classification structure within the general ledger account for grants and ensures claims/costs are in compliance with the appropriate regulations. This position is responsible for grant accounts payable activities and reconciles with expenditure reports and claims.	$45,565
0.20	William Gaitan, Contract Analyst, Processes contracts and assures compliance with local, state and federal regulations.	$19,672
	Personnel Total	**$540,787**

Fringe Benefits

Percentage	Category	Amount
18.08%	Insurance(Medical/Life)	$97,774
6.20%	Social Security	$33,529
10.00%	Retirement	$54,079
1.50%	Workers Compensation	$8,112
4.22%	Others (Disability, Unemployment, Medicare, Life Insurance, and Supp. Ret.)	$22,821
	Fringe Benefit Total	**$216,315**

Travel

Local	Amount
To purchase bus passes to travel to sites ($75 bus pass/mo. x 2 staff x 12 mo)	$1,800
Local Travel Sub-Total	**$1,800**
Long Distance	**Amount**
To cover costs for annual RWPA grantee meetings (Domestic airfare$600 + lodge and transportation $200	$2,800

PART A ADMINISTRATIVE BUDGET NARRATIVE

RECIPIENT: San Francisco Dept of Public Health

GRANT NUMBER: H89HA00006

FISCAL YEAR: 2019-20

Long Distance Travel Sub-Total	**$2,800**
Travel Total	**$4,600**

Equipment	**Amount**
Equipment Total	**$0**

Supplies	**Amount**
General office supplies: ($539 per month x 12)	$6,471
Supplies Total	**$6,471**

Contractual	**Amount**
Admin Contracts (Grant Writing/Consulting)	$63,500
Planning Council	$433,474
Quality Mgmt	$367,500
Primary Care Services	$9,151,733
Support Services	$5,392,843
Contracts Total	**$15,409,049**

Construction
Not Applicable

Other	
These supplies are necessary to properly care out adminstrative and clinical functions required by Ryan White Part A grant. Rent 22,000, Training 3,000	$25,000
Other Costs Total	**$25,000**

Total Direct Cost
$16,202,223

Total Indirect Cost	
Indirect Cost Total	**$0**

Part A Administrative Total
$16,202,223

PLANNING COUNCIL SUPPORT BUDGET NARRATIVE

RECIPIENT: SFDPH/Shanti Planning Council
GRANT NUMBER: H89HA00006
FISCAL YEAR: 2019-20

Personnel

FTE	Name, Position, Duties	Amount
1.00	Mark Molner, Program Director, Responsible for the direction and executive oversight of all HHSPC Support tasks, functions as an alternative liaison between the HHSPC and stakeholders, government entitites, and community bodies	$85,000
1.00	Dave Jordan, Community Services Manager, Responsible for coordination and implementation of all training, orientations, manages evaluations of all Council meetings, supervises annual needs assessment, conducts outreach, provides administrative support and management as needed	$50,000
1.00	Alie Cone, Program Manager, Responsible for HHSPC administrative support and coordination, point of contact for and coordination of meeting presenters and vendors, supervision of website maintenance, program support for annual needs assessement	$50,000
1.00	Liz Strum, Program Coordinator, Responsible for notetaking at Council meetings, agendas and minutes, maintenance of recordings, maintenance of website, coordinates requests for information to and from HHSPC members, helps coordinate outreach meetings	$45,000
	Personnel Total	**$230,000**

Fringe Benefits

Percentage	Category	Amount
$0	Insurance(Medical/Life)	$15,456
$0	Social Security	$14,260
$0	Retirement	$6,900
$0	Workers Compensation	$3,450
$0	Others (Disability, Unemployment, Medicare, Life Insurance, and Supp. Ret.)	$2,760
	Fringe Benefit Total	**$42,826**

Travel

Local	Amount
Council Member travel costs between Marin, San Mateo, and San Francisco; staff travel between agency and	$1,058
Local Travel Sub-Total	**$1,058**

Long Distance	Amount
Long Distance Travel Sub-Total	**$0**
Travel Total	**$1,058**

Equipment

Equipment	Amount
Equipment Total	**$0**

Supplies

Supplies	Amount
General office supplies such as pens, paper, binders, miscellaneous supplies, and postage expenses for client	$3,000
Supplies Total	**$3,000**

Contractual

Contractual	Amount
Contracts Total	**$0**

Construction

Not Applicable

Other

RENT: Montly rent expense for the proportion of office space utilized by ($1,000/Mos X 12 mos)	$12,000
Utilities, Bldg Maintenance, Supplies & Repair: Monthly Utility expense for proportionate program	$3,000
PHONE: Costs for phone and internet usage, proportionate to program utilization (100 X 12 mos)	$1,200
PRINTING and REPRODUCTION: Costs for printing and reproduction of Council-related documents and	$1,200
INSURANCE: Proportionate share of cost for general liability insurance required for operations. (150 X	$1,800
RENTAL of EQUIPMENT: Proportionate share of cost to operate leased copiers for printing and	$2,400
ANNUAL Summit, ongoing training and other council related meetings: ($500 per monthly Council meeting	$7,407
NEED Assessement: As needed for participant incentives and intern stipend	$3,500

PLANNING COUNCIL SUPPORT BUDGET NARRATIVE

RECIPIENT: SFDPH/Shanti Planning Council

GRANT NUMBER: H89HA00006

FISCAL YEAR: 2019-20

Other Costs Total	**$32,507.00**

Total Direct Cost	
	$309,391
Total Indirect Cost	
8.89% of direct cost	$27,486
[Insert indirects cost description/justification]	
Indirect Cost Total	**$27,486**
Planning Council Support Total	
	$336,877

PLANNING COUNCIL SUPPORT BUDGET NARRATIVE

RECIPIENT: SFDPH/AIDS Legal Referral Panel
GRANT NUMBER: H89HA00006
FISCAL YEAR: 2019-20

Personnel

FTE	Name, Position, Duties	Amount
1.00	Gina Gemello, HCAP Attorney: Will conduct outreach activities, provide advocacy, and offer mediation services; will provide technical assistance to providers; will prepare quarterly reports on consumer issues and their resolution	$56,646.00
0.04	Bill Hirsh, Executive Director: Will supervise the HCAP Attorney; will oversee agency collaborations and attorney-client relations; and will conduct program evaluation activities and oversee compliance with contract objectives and requirements.	$3,964.00
	Personnel Total	**$60,610.00**

Fringe Benefits

Percentage	Category	Amount
9.10%	Insurance(Medical/Life)	$5,940
6.20%	Social Security	$4,637
3.00%	Retirement	$818
1.50%	Workers Compensation	
1.20%	Others (Disability, Unemployment, Medicare, Life Insurance, and Supp. Ret.)	$1,333
	Fringe Benefit Total	**$12,728**

Travel

Local	Amount
Local Travel Sub-Total	**$0**
Long Distance	**Amount**
Long Distance Travel Sub-Total	**$0**
Travel Total	**$0**

Equipment

Equipment	Amount
Equipment Total	**$0**

Supplies

Supplies	Amount
General office supplies @ $12,000 and $6,000 postage expenses annually charged proportionate to program	$1,431
Supplies Total	**$1,431**

Contractual

Contractual	Amount
Contracts Total	**$0**

Construction

Not Applicable

Other

RENT: Annual rent expense for the proportion (7.95%) of space utilized by program. (93,938 X 7.95%)	$7,468
UTILITIES: Annual telephone expenses for proportionate program utilization (7.95%) (12,000 X 7.95%)	$954
PRINTING & Reproduction: General photocopying expenses for proportionate program utilization (7.95%).(2,000 X 7.95%)	$159
INSURANCE: General Liability Insurance is charged on a shared cost basis: $5,000 x 7.95% = $398. Professional Liability Insurance is allocated based on a per-staff attorney basis. The per-staff attorney cost is $2,495. $2,495 x 1.00 FTE staff attorneys = $2,495.	$2,893
STAFF Training: For classes, workshops, conferences and training materials for ALRP's staff. (73.58/mos X 12 mos)	$883
Equipment Rental & Repair: For rental of ALRP's photocopier and postage meter and for equipment maintenance agreements and repair costs. (8,800 X 7.95%)	$700
CONSULTANT: For computer and database consultants with proportionate program utilitization (7.95%). (10,000 X 7.95%)	$795
Other Costs Total	**$13,852**

PLANNING COUNCIL SUPPORT BUDGET NARRATIVE

RECIPIENT: SFDPH/AIDS Legal Referral Panel
GRANT NUMBER: H89HA00006
FISCAL YEAR: 2019-20

Total Direct Cost	
	$88,621
Total Indirect Cost	
9% of direct cost	$7,976
Indirect Cost Total	**$7,976**
Planning Council Support Total	
	$96,597

PART A CLINICAL QUALITY MANAGEMENT BUDGET NARRATIVE

RECIPIENT: San Francisco Dept of Public Health/HR360

GRANT NUMBER: H89HA00006

FISCAL YEAR: 2019-20

Personnel

FTE	Name, Position, Duties	Amount
1.00	Nina Davis, Office Manager/Admin Assistant, General Office Manager Functions for HHS section. Coord of calenders for HHS Director and Adminstrator	$54,500.00
1.00	Deanna Chan, Invoice Analyst, Analysis and processing of HHS and HPA contract invoices and all tasks assocatied with budget work	$64,896.00
1.00	Vacant, Public Service Aide/Office Assistant, Filing, PDF, correspondences, note taking at meeting, other duties as assigned.	$42,000.00
	Personnel Total	**$161,396.00**

Fringe Benefits

Percentage	Category	Amount
14.86%	Insurance(Medical/Life)	$23,983.45
6.20%	Social Security	$10,006.55
3.00%	Retirement	$4,841.88
1.50%	Workers Compensation	$2,420.94
6.44%	Others (Disability, Unemployment, Medicare, Life Insurance, and Supp. Ret.)	$10,394.18
	Fringe Benefit Total	**$51,647.00**

Travel

Local	Amount
Local Travel Sub-Total	**$0.00**

Long Distance	Amount
Long Distance Travel Sub-Total	**$0.00**
Travel Total	**$0.00**

Equipment	Amount
Equipment Total	**$0.00**

Supplies	Amount
Supplies Total	**$0.00**

Contractual	Amount
Subcontractors: Trainers required for Quality Management related trainings for staff and providers. Consultants as needed fo IT/data mapping and importing for QI related analysis	$122,639.00
Contracts Total	**$122,639.00**

Construction

Not Applicable

Other

Other Costs Total	**$0.00**

Total Direct Cost

$335,682.00

Total Indirect Cost

An allocation of administrative & support staff salary and related fringe benefits and general overhead expenses related to the contract. Rate is 10% of Direct Cost	$31,818.00
Indirect Cost Total	**$31,818.00**

Part A Clinical Quality Management Total

$367,500.00

MAI ADMINISTRATIVE BUDGET NARRATIVE

RECIPIENT: San Francisco Dept of Public Health
GRANT NUMBER: H89HA00006
FISCAL YEAR: 2019-20

Personnel

FTE	Name, Position, Duties	Amount
0.50	Marsha Herring, Compliance Program Manager, Provides oversight of contractor performance and compliance for Ryan White Part A grants	$57,544
	Personnel Total	**$57,544**

Fringe Benefits

Percentage	Category	Amount
17.58%	Insurance(Medical/Life)	$10,116
6.20%	Social Security	$3,568
10.50%	Retirement	$6,042
1.50%	Workers Compensation	$863
4.22%	Others (Disability, Unemployment, Medicare, Life Insurance, and Supp. Ret.)	$2,427
	Fringe Benefit Total	**$23,017**

Travel

Local	Amount
Local Travel Sub-Total	**$0.00**
Long Distance	**Amount**
Long Distance Travel Sub-Total	**$0.00**
Travel Total	**$0.00**

Equipment

	Amount
Equipment Total	**$0.00**

Supplies

	Amount
Supplies Total	**$0.00**

Contractual

	Amount
Primary Care Services	$725,048
Contracts Total	**$725,048**

Construction

Not Applicable

Other

Other Costs Total	**$0.00**

Total Direct Cost

$805,609

Total Indirect Cost

Indirect Cost Total	**$0.00**

MAI Administrative Total

$805,609

OMB Number: 4040-0007
Expiration Date: 01/31/2019

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Completed on submission to Grants.gov	Director of Operations
APPLICANT ORGANIZATION	DATE SUBMITTED
San Francisco Dept of Public Health	Completed on submission to Grants.gov

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BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 01/31/2019

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. RWHAP Part A Adminstrative		$	$	$ 1,209,587.00	$	$ 1,209,587.00
2. RWHAP Part A MAI				805,609.00		805,609.00
3. RWHAP Part A Quality Mgmt (CQM)				367,500.00		367,500.00
4. RWHAP Part A HIV Services (Contractual)				13,819,527.00		13,819,527.00
5. Totals		$	$	$ 16,202,223.00	$	$ 16,202,223.00

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SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) RWHAP Part A Adminstrative	(2) RWHAP Part A MAI	(3) RWHAP Part A Quality Mgmt (CQM)	(4) RWHAP Part A HIV Services (Contractual)	Total (5)
a. Personnel	$ 483,243.00	$ 57,544.00	$	$	$ 540,787.00
b. Fringe Benefits	193,299.00	23,017.00			216,316.00
c. Travel	4,600.00				4,600.00
d. Equipment					
e. Supplies	6,471.00				6,471.00
f. Contractual	496,974.00	725,048.00	367,500.00	13,819,527.00	15,409,049.00
g. Construction					
h. Other	25,000.00				25,000.00
i. Total Direct Charges (sum of 6a-6h)	1,209,587.00	805,609.00	367,500.00	13,819,527.00	$ 16,202,223.00
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$ 1,209,587.00	$ 805,609.00	$ 367,500.00	$ 13,819,527.00	$ 16,202,223.00
7. Program Income	$	$	$	$	$

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. RWHAP Part A Adminstrative	$	$	$	$
9. RWHAP Part A				
10. RWHAP Part A Quality Mgmt (CQM)				
11. RWHAP Part A HIV Services (Contractual)				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 16,202,233.00	$ 4,050,558.00	$ 4,050,558.00	$ 4,050,558.00	$ 4,050,559.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 16,202,233.00	$ 4,050,558.00	$ 4,050,558.00	$ 4,050,558.00	$ 4,050,559.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. RWHAP Part A Adminstrative	$	$	$	$
17. RWHAP Part A				
18. RWHAP Part A Quality Mgmt (CQM)				
19. RWHAP Part A HIV Services (Contractual)				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: 16,202,223

22. Indirect Charges: 0

23. Remarks:

OMB Number: 4040-0010
Expiration Date: 12/31/2019

Key Contacts Form

*** Applicant Organization Name:**

San Francisco Dept of Public Health

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Project Adminstrator

Prefix:	
* First Name:	Dean
Middle Name:	
* Last Name:	Goodwin
Suffix:	
Title:	Assistant Director of HIV Health Services

Organizational Affiliation:

* Street1:	25 Van Ness Ave, 8th Fl
Street2:	
* City:	San Francisco
County:	
* State:	CA: California
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	94102-6012
* Telephone Number:	628-2067675
Fax:	
* Email:	Dean.Goodwin@sfdph.org

OMB Number: 4040-0010
Expiration Date: 12/31/2019

Key Contacts Form

*** Applicant Organization Name:**

San Francisco Dept of Public Health

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 2 Project Role:** Fiscal Contact

Prefix:	
* First Name:	Sajid
Middle Name:	
* Last Name:	Shaikh
Suffix:	
Title:	Sr Administrative Analyst

Organizational Affiliation:

* Street1:	1380 Howard St
Street2:	
* City:	San Francisco
County:	
* State:	CA: California
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	94103-2614
* Telephone Number:	415-255-3512
Fax:	
* Email:	sajid.shaikh@sfdph.org

OMB Number: 4040-0010
Expiration Date: 12/31/2019

Key Contacts Form

*** Applicant Organization Name:**

San Francisco Dept of Public Health

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 3 Project Role:** Accountant

Prefix:	
* First Name:	Olivia
Middle Name:	
* Last Name:	David
Suffix:	
Title:	Principal Accountant

Organizational Affiliation:

* Street1:	1380 Howard St
Street2:	
* City:	San Francisco
County:	
* State:	CA: California
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	94103-2614
* Telephone Number:	415-255-3457
Fax:	
* Email:	olivia.david@sfdph.org