



# **2010 HIV HEALTH SERVICE SUMMARY SHEETS MEGATRENDS**

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**Bill Blum**

**Interim Director HIV Health Services**

**SF DPH**

# I. HIV HEALTH SERVICE SYSTEM TRENDS

- With the exception of Part B SOA direct funded programs, the San Francisco HIV Ryan White Care system has not significantly changed in the past year.
- Trends within the system are on-going and have been reported in previous years.
- The following highlights more global issues for HHSPC Consideration for the Prioritization and Allocation Retreat and beyond regarding the SF HIV System of Care.

## II. ADDITIONS AND CHANGES TO SF SERVICE CATEGORIES (1 OF 2)

- Block Grant funding State Office of AIDS RWPB Direct Funded Programs (HIV Service Programs) and reduction of funding levels to San Francisco resulted in a shortfall to some local programs.
  - Per SOA HHS has discretion over these funds and SOA oversees funding decisions.
  - HHS requested input from HHSPC on the allocation of these funds.
  - To overcome the short fall HHSPC voted to add the following service categories at level funding in FY2010 and at level or reduced funding pending RWP A FY2011 award to SF EMA:
    - Therapeutic Monitoring Program (t-cell viral load and resistance testing) under the HRSA service category of **Early Intervention**.
    - The AIDS Case Management Programs under the HRSA category of **Medical Case Management**.

Note: The number of programs reduced from three to one.
    - Early Intervention Programs (EIP) have been absorbed into the Centers of Excellence under the HRSA service category of **Ambulatory/Out Patient Medical Care**.
    - Residential AIDS Living Facilities (RALF) under the service category of **Housing**.

## II. ADDITIONS AND CHANGES TO SF SERVICE CATEGORIES (2 OF 2)

- Due to California State Budget Crisis there were significant reductions to Denti-Cal Coverage in FY 20010.
  - To overcome the short fall HHSPC voted to augment funding to the Dental service category to backfill Denti-Cal cuts for FY2010 under the HRSA service category of **Oral Health**.

Note: this services were resolicited and there are now three providers.

## II. OVERARCHING ISSUES (1 OF 4)

- **Medical Case Management, Medical Care, Treatment Adherence, Mental Health and Out Patient Substance Use Services:**
  - Clients continue to present with **multiple diagnoses** (HIV disease, HCV, psychiatric illness and/or substance use issues) and subsequently require more specialized intensive care.
- **Primary Medical Care, Treatment Adherence, Facility Based Home Care**
  - Many clients also have **co-occurring health issues** such as diabetes, renal failure, and Hepatitis C. Additional co-morbidity factors can include long-term HIV infection, long-term use of anti-HIV medications, long-term alcohol and recreational drug use, aging, and drug resistance; all of these factors intensify service provision complexity.

**Hepatitis C co-infection continues to impact HIV care needs.**

## OVERARCHING ISSUES (2 OF 4)

### ○ **Primary Medical Care and Mental Health**

- Ongoing need for expertise in HIV and **aging** issues emerging issues:
  - integration of elder adult and HIV social service systems to address challenges of depression and isolation.
  - increased role of pharmacist for complex interactions.
  - potential increased need for specialty care.

### ○ **Medical Case Management**

- Case management continues to be the “glue” connecting and maintaining clients to/in care.
- Many case management programs are currently at or exceeding contractual client capacity.

## OVERARCHING ISSUES (3 OF 4)

### ○ **Prevention with Positives and STD Treatment (Primary Medical Care, Mental Health, Out-Patient Substance Abuse, Medical Case Management)**

- STD co-infections continue to impact HIV + patients. STDs can significantly increase an HIV infected person's viral load, increasing the likelihood of HIV infection transmission.
- HIV Prevention Services (HPS) is integrating with HHS funding and service delivery for treatment adherence and maintenance in care through solicitation process and coordinated outcome measures.

## OVERARCHING ISSUES (4 OF 4)

### ○ Facility Based Care, Housing Services

- As HIV disease becomes increasingly chronic with more morbidity (illness) and less mortality (death) there is an increasing caseload in the EMA, with less turnover and longer waits for some Ryan White-funded programs slots.
- Inadequate affordable housing options continue to make exiting out-of-facility-based housing difficult for some (and limit housing opportunities for all low and middle income tenants with HIV).

## III. SFDPH TRENDS

### ○ Departmental Structural Changes:

- Sister partner health care systems within DPH have changed through integration and consolidation.
  - Last year all contract development and monitoring functions were centralized in to the Community Programs Business Office.
  - Substance Use and Mental Health Units were combined into Community Behavioral Health Services (CBHS).
    - The residential and outpatient substance abuse and mental health services have been significantly restructured through the a solicitation process.
      - HIV specific residential substance use treatment and residential mental health treatment have not significantly changed.
    - CBHS is in process of being integrated into Community Oriented Primary Care (COPC). The new unit is called Community Health Care (CHC).

# IV. STATE AND FEDERAL TRENDS

## (1 OF 2)

- Health Care Reform

- Expansion of uninsured clients covered as eligibility becomes based exclusively on income not disease stage.
- Focused on the medical home model.
- HRSA Health Center Program may become the medical backbone for all medical including HIV care. Service delivery may be provided through community health care centers

- Include “Federally Qualified Health Centers” (330 Clinics), 330 Look alike Clinics and Clinics operated by Tribal Organizations.
- HIV/AIDS Bureau (HAB) may not have the lead role in HIV care.

- Unknown impact on Ryan White Programs Legislative Extension set to sunset in 2013.

Unknown future role of community planning bodies.

# IV. STATE AND FEDERAL TRENDS

## (2 OF 2)

- Shortfall for National ADAP program

- Currently estimated at over \$126M.
- Emergency legislation to cover shortfall is still pending.
- As of June 2010, 12 States with over 1,200 clients on waitlists.
- California ADAP solvency for current year.

Community groups have expressed concern that funding may be inadequate for full fiscal year.

- Federal focus on integration and Coordination of HIV funding for Care and Prevention

Recommendations from (Office on National AIDS Policy (ONAP)).

Reconstitution of Presidential Advisory Council on HIV/AIDS (PACHA) .

## IV. OPPORTUNITIES

- Efficiency and Creativity
  - How do we best address duplication in the system?
  - Can HHSPC help to foster increased integration among HIV community providers?
  - Are there populations that need additional attention or funding?
    - e.g. HIV Services for People of Transgender Experience
- Augmented and Strengthened Partnership between DPH and HHSPC
  - Position the SF EMA HIV service delivery system in the optimal position for health care reform.
  - Further strengthening the advisory role of the HHSPC in:
    - HIV and Aging
    - HIV and HCV Co-infection
    - HIV and Housing
    - Integration of HIV Care and Prevention